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**Working therapeutically with diversity in men:  
Offering a relational space for wholeness**

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**Portfolio submitted in the fulfilment of the requirements for the  
Professional Doctorate in Counselling Psychology (DPsych)**

**City, University of London  
Department of Psychology**

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For all the unconditional and precious love she gave to me,

And her genuine curiosity to understand and accept humans as they are:

These very values that underpin this portfolio.

Firstly, I would like to acknowledge and thank the six participants for sharing their valuable experiences about matters often difficult to talk about. Hopefully this research will encourage clinicians to expand their empathy and embody an inclusive and a non-discriminatory practice.

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## **Declaration**

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## **Preface:**

### **A Presentation of the Various Components of the Portfolio**

#### **1. Introduction to the portfolio**

This section will introduce the three components that comprise this Doctoral Portfolio: a research study, a combined client case study/process report, and a publishable paper.

These components hopefully demonstrate my ability to embrace a 'scientist-practitioner' and a 'reflective-practitioner' approach to research and therapeutic practice, which integrates "...the scientific demand for rigorous empirical inquiry with a firm value base grounded in the primacy of the counselling/psychotherapeutic relationship" (BPS, 2005, p.1). Furthermore, the different pieces of this portfolio can infer my own challenge and growth as a trainee Counselling Psychologist in becoming aware of my own *internalised homophobia* (Davies & Aykroyd, 2002) and *gender empathy gap* (Barry, 2016) when working therapeutically with different men clients.

The three distinct components comprising this portfolio share four pertinent threads: (a) a relational space for wholeness in therapy, (b) male clients, (c) myself, as a gay male researcher and therapist and (d) my pluralistic view of being.

##### **1.1. *A relational space for wholeness in therapy***

During my academic studies, clinical training and personal therapy, I was faced with my own blind spots and presumptions around gender and sexuality that could weaken my contact with my authentic self as a whole and, therefore, my clients too. Indeed, Bor, Chaudry and Miller (2017) clarify that the therapist's challenge "is to listen to and endeavour to reach an understanding of, the client's problems in such a manner that one's prior experience, among other factors, does not close you off from the possible meaning of the client's description of their experience" (p.270). Langdridge (2014) states that it is the therapist's responsibility to gain sufficient awareness about sexuality in order to work therapeutically with sexual minority clients.

As such, the research included in this portfolio aimed to explore the unhelpful experiences of self-identified gay men (SIGM) in therapy. All participants described their need to be accepted as a whole in therapy as not being met. These participants elaborated on how difficult it was for them to bring the parts of themselves linked to their sexual identity in the therapy room. Counselling Psychology, with its humanistic ethos, sees all individuals as unique. Accordingly, the therapist aims to offer clients of all sexual orientations a nourishing therapeutic relationship where they can be everything they are and become their full

potential (Douglas, Woolfe, Strawbridge, Kasket, & Galbraith, 2016). As such, the combined client case study/process report of the present portfolio aimed to provide a therapeutic relationship for a heterosexual male client to get in touch and accept all parts of himself in order to alleviate his distress.

### 1.2. ***Male clients***

During my clinical placements, I was often the only male therapist. Many of the male clients in the different services where I have worked had a preference of working with a 'male therapist'. Consequently, most of the clients I worked with were men. I felt challenged therefore by my predominantly male caseload, as I assumed women to be more willing to engage in emotional work. That is when I felt intrigued to start reflecting on western and global unhelpful societal messages that discourage men from embracing their emotions, expressing their vulnerability or asking for help (Brannon, 2016).

In line with the APA (2018) *Guidelines for Psychological Practice with Boys and Men*, the different parts of this portfolio include diverse masculinities and aim to generate knowledge that can encourage a therapeutic practice that sees men beyond restrictive conditions, by giving space to individual expressions of male gender identities. This is particularly relevant within the thesis section focusing on SIGM in therapy. In line with the Feminist and Queer theories, this portfolio diverts from the traditional, dichotomous and often unhelpful views of what being a man means in psychology (Barker & Langdridge, 2009) and aims to give voice to otherwise silenced male identities.

### 1.3. ***Myself, as a gay male researcher and therapist***

This portfolio entails my research work with six gay men and my therapeutic work with a heterosexual man. My contact with these individuals inevitably brought to the surface memories and feelings about my own sense of being a gay man in a predominantly heterosexual world. Both the research and the case study encompass my own struggle about being raised in a patriarchal society where a man is not allowed to express vulnerability and a gay man is regarded as invisible or even an abomination. This struggle has driven the content of this portfolio. Meanwhile, the content of the portfolio has driven my growth as a human and a Trainee Counselling Psychologist. I was challenged to face my own fears and experiences of discrimination, as well as strive to understand the Other and respect the difference and diversity that may exist within and between people who identify as men.

#### 1.4. ***My pluralistic view of being***

Focusing on diversity and subjectivity, all components included in this portfolio are approached through a pluralistic view of being. Consistent with Counselling Psychology values (Douglas et al., 2016), such a view emphasises that each individual experiences the world in a unique way. Consequently, the epistemological lens and methodology used to research the unhelpful experiences of SIGM in therapy encapsulate the existence of multiple realities and meanings, and touch on the concepts of subjectivity and intersubjectivity. The pluralistic approach to counselling and psychotherapy encourages clients to express what they want from therapy and what feels most helpful for them (Cooper & McLeod, 2011). Consistently, the research within this portfolio attempts to invite SIGM clients to talk about what they may have wanted from therapy and did not have.

The therapeutic modality embodied in the combined case study/process report is also driven by a pluralistic epistemology (Cooper & Dryden, 2015). This means that as a therapist I hold the notion that human beings are unique and multi-layered. As such, they may benefit from different ways of working at different times. Accordingly, in my role as a therapist I placed the uniqueness and holistic nature of my client and his preferred ways of working above any generalised theory (Cooper & McLeod, 2011).

## 2. **Sections of the portfolio**

### 2.1. ***Section A: Doctoral Thesis:*** “I wasn't feeling like I belonged in my skin”: How self-identified gay men in the UK experience unhelpful incidents in therapy

The original piece of research included in this portfolio aims to explore how SIGM in the UK experience unhelpful incidents in therapy, supposing that these incidents were perceived to be linked to their sexual/affectional orientation. This research can hopefully demonstrate my ability to understand different research methodologies and to accordingly design psychological studies ethically (BPS, 2014; HCPC, 2015).

In its first chapter I discuss how recent reports and past qualitative research indicate that gay men may still experience unhelpful incidents in therapy in relation to their sexual orientation, hindering their psychological well-being. There seems to be little available research on *how* SIGM experience unhelpful incidents in therapy and such research lacks depth. Samples of existing qualitative research lack homogeneity and include only a few gay men. More studies are, therefore, needed in order to look at these experiences in depth, as well as to enhance the transferability of our current insights regarding these experiences.



For this reason, the research in this portfolio employs Interpretive Phenomenological Analysis (IPA). As I explain in the Methodology chapter, IPA uses suitable methods that can enhance our understanding of an individual's lived experience and sense-making of it on a deeper than descriptive level. However, the depth of the world the participant inhabits is not fully and directly accessed. Rather, the researcher engages in interpretations and attempts to make sense of the participant's sense making (Langdridge, 2007). The data was collected through individual, semi-structured interviews (approximately 60 minutes long) of six SIGM (aged 25-57). This method is suitable to collect rich accounts of conscious, subjective lived experiences (Smith, Flowers, & Larkin, 2009).

Through IPA, the following Master Themes emerged: Making Sense of Disconnection, A Rejecting Therapy for a Gay Individual, and Understanding the Impact of Unhelpful Incidents Outside Therapy. Through the Analysis chapter I aim to come as close as possible to the lived experience of the participants, based only on their accounts. Through the Discussion Chapter I aim to enhance these insights relating the findings with the existing relevant literature.

Mearns and Cooper (2018) would argue that the accounts of the participants of this study revealed that they were not provided with a relationship where their therapists strived to reach out to their Otherness. The Otherness of the participants was not validated or valued, to use Buber's (1958) words, as men who exist in their "own peculiar form" and have "the right to do so" (Friedman, 1985, p.134). The findings of this study are consistent with the importance the Division of Counselling Psychology (BPS, 2005) places on the therapeutic relationship. Counselling Psychologists are expected to demonstrate an understanding of the therapeutic relationship as conceptualised in different models (HCPC, 2015), as well as the ability to engage in relational practice with all clients (BPS, 2015).

It is hoped that the insights of this research can encourage therapists to enhance their empathic understanding when working with gay men and contribute to a more effective, non-discriminatory, ethical and therapeutic practice with other sexual, gender and intersecting identities. The empathic understanding provoked by this study can guide the Counselling Psychologist's ethical thinking not just in the consulting room with these clients, but in their wider roles in the society as well (Olsen, 2010).

2.2. **Section B: Combined Client Study/Process Report:** *My endeavour to work therapeutically with my client as a whole: A Person-Centred Assimilative Integration Approach*

The combined client study/process report demonstrates my work with a heterosexual man and my challenge to reach and work with the different parts of him that seemed to be in conflict causing him distress. My pluralistic epistemology (Gabriel, 2015) and Counselling Psychology training allowed me to draw from various evidence-based approaches of therapy that best met my client's preferences and needs (BPS, 2015; HCPC, 2015; NICE, 2011). Consequently, I aimed to implement different interventions that honoured the subjective and intersubjective human nature of the therapeutic encounter (BPS, 2015).

I chose to include this piece of work as it can specifically show how third-wave Cognitive Behaviour approaches can be assimilated in the Person-Centred Approach to enhance the therapeutic process when working with different 'configurations' or 'parts of self' (Mearns & Cooper, 2018). I feel that my client's bravery to engage in therapeutic work and my focus on building a nourishing therapeutic relationship seem to validate existing research showing both the therapeutic relationship and the client's engagement as vital for therapeutic change (Cooper, 2008; Norcross, 2011).

Throughout the case study and the process report from session 14/20, the therapeutic processes are critically and reflectively discussed with a focus on the therapeutic relationship. This reflections can hopefully demonstrate my ability to practice ethically and competently (BPS, 2005, 2014; HCPC, 2015). Consistently, I critically reflect on the challenges imbedded in my work with this client and the constructive role of supervision and personal therapy in order to overcome them.

2.3. **Section C: Publishable paper:** *"It's not really being very connective": How self-identified gay men in the UK experience unhelpful incidents in psychological therapy*

This section aims to demonstrate the trainee's ability to compose a publishable paper based on an original piece of research. Consequently, I endeavoured to produce a publishable paper that comprises the material included in the Thesis (Section A) in a concise yet rich and informative form. This publishable paper was developed in accordance with the specific guidelines for publishing of the *Psychology and Psychotherapy: Theory Research and Practice* journal (see Appendix A of Section C).

Several renowned journals were considered prior to selecting this specific journal. These journals were periodicals that focus on sexuality, due to the focus of SIGM. However, I consider my piece of research to incorporate experiences relevant to psychological and psychotherapeutic processes. Moreover, I consider the anti-discriminatory therapeutic practice for SIGM clients as the responsibility of every psychological and psychotherapeutic practitioner and professionals from all relevant backgrounds, beyond the scope of the field of sexuality.

The main challenge upon composing this article was to include as many quotes as possible to make the voice of the participants heard. In line with IPA's principles (Smith et al., 2009), I strived to give voice to their idiographic, subjective lived experiences by including individual quotes from all the participants throughout the Findings section in the article. As in the Thesis (Section A) and in line with the BPS guidelines (Shaw et al., 2012), it is hoped that the readers of this article could gain insights that would encourage them to expand their empathic understanding when working therapeutically with SIGM and other sexual, gender and intersecting identities.

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## **Section A**

**Doctoral Thesis:** "I wasn't feeling like I belonged in my skin":  
How self-identified gay men in the UK experience unhelpful incidents  
in therapy

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## 1. Abstract

Contemporary psychological research and practice in Western Societies oppose pathologising perspectives about same-sex attraction. Nonetheless, recent research indicates that gay men may still experience unhelpful incidents in therapy in relation to their sexual/affectional orientation. This can hinder their psychological well-being. However, there is hardly any research focusing on how self-identified gay men (SIGM) experience these unhelpful incidents. Such research could help clinicians enhance their empathic understanding when working therapeutically with this client group. The present study addresses this gap in the literature and offers insight into the phenomenon of unhelpful therapy experiences of SIGM clients in relation to their sexual/affectional orientation. The data was collected through individual, semi-structured interviews of six SIGM (aged 25-57) describing how they currently experience these unhelpful incidents. Interpretative Phenomenological Analysis shed light on the following Master Themes: Making Sense of Disconnection, A Rejecting Therapy for a Gay Individual, and Understanding the Impact of Unhelpful Incidents Outside Therapy. The relevance of these findings for Counselling Psychology and their implications for practice, training and future research are discussed.

**Keywords:** *psychotherapy, counselling, unhelpful experiences, gay, sexual minorities, qualitative research.*

## 2. Chapter One: Literature review

This literature review is composed of four parts. The first part will discuss sexual minorities and discrimination with a specific focus on mental health. This is because the focus of this research is on the unhelpful experiences of SIGM in therapy, where these experiences were thought to be linked to their sexual/affectional orientation. The term 'sexual minorities' will be used throughout this study to account for individuals the existing literature defines as lesbian, gay and bisexual. However, the author recognises that there are more sexual/affectional orientations and myriad other communities within the Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual (LGBTQIA+) population (Griffith et al., 2017). 'Gender minorities' will encompass trans individuals and people who do not adopt the binary terminologies of 'men and women'. The abbreviation of GSRD will stand for gender, sexual, and relationship (e.g., consensual non-monogamy) diverse people (Richards, Bouman, & Barker, 2017). Existing literature uses several terms to define the negative attitudes towards gay men and other sexual minorities or the idea that 'heterosexual' is a superior way of being. Such terms are *homophobia* (e.g., Weinberg, 1972), *heterosexism* (e.g., Sears, 1997) and *heteronormativity* (e.g., Goodman & Gorski, 2014). Herek, Cogan and Gillis (2009) offered the term *sexual stigma* to "refer broadly to the negative regard, inferior status, and

relative powerlessness that society collectively accords anyone associated with non-heterosexual behaviours, identity, relationships, or communities” (pp. 33). These terms will be referenced in this paper.

The second part will explore the existing literature on the experiences of clients in therapy and a rationale for researching unhelpful experiences of SIGM in particular. The terms ‘psychotherapy’ and ‘counselling’ encompass different meanings (Ward, 2016). Nonetheless, the existing literature on the unhelpful experiences of clients in therapy does not differentiate between the terms of ‘counselling’, ‘psychotherapy’, ‘psychological therapy’ and other terms that define the delivery of talking therapy. The present study uses the word ‘therapy’ to incorporate all of these terms.

The third part will review the existing research on the unhelpful experiences of sexual minorities and specifically SIGM in therapy.

In the fourth part, gaps in the literature will be identified, providing a rationale for the present study. Finally, the relevance of this study to Counselling Psychology will be explored.

## **2. 1. Sexual Minorities and Mental Health**

### **2.1.1. Sexual Stigma**

During the last two decades, the social attitudes towards same-sex attraction in Western societies have improved remarkably (Lea, de Wit, & Reynolds, 2014). However, being a gay man or a sexual minority today also means that in several countries across the world you could be physically and emotionally tortured, detained or killed in the name of a religion or law (Dicklitch-Nelson, Thompson, Yost, & Draguljić, 2019). In Western societies, including the UK, several political and religious forces have persistently drawn on moral and legal arguments to oppose the civil and human rights of sexual minorities (Moradi, Mohr, Worthington, & Fassinger, 2009; Bidell, 2016). Perhaps not surprisingly then, sexual minorities in the UK still report high levels of abuse and discrimination on a daily basis (Bachmann & Gooch, 2017). A national survey launched by the Government’s Equality Office (2018a) showed that two-thirds of 108,000 LGBT individuals would avoid holding hands in public, for fear of negative responses.

### **2.1.2. Minority Stress Theory**

The Minority Stress theory proposes that sexual stigma and discrimination can create a hostile and stressful social environment for sexual minorities, impacting their psychological and physical health negatively (Meyer, 2003). Minority Stress theory is the result of internalised homophobia, perceived stigma and experience of discrimination (Meyer, 1995,



2003). Internalised homophobia refers to the internalisation of the society's negative attitudes towards homosexuality. Perceived stigma refers to the extent that sexual minorities perceive these negative attitudes by others, and the expectation for discriminatory treatment (Lea et al., 2014). Additional layers of inequality regarding one's race, ethnicity, and socioeconomic status may fortify minority stress and its complications (Institute of Medicine, 2011). Sexual stigma can be manifested in the form of bullying, verbal and physical abuse, and social marginalization. It can be exercised by people in the workplace, school and community, and one's own family (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Coker, Austin, & Schuster, 2010; Ryan, Huebner, Diaz, & Sanchez, 2009).

Research findings consistently suggest that sexual minorities experience psychological distress linked to the social discrimination they encounter because of their stigmatized status (Meyer, 2003; Szymanski & Meyer, 2008; Moradi, van den Berg, & Epting, 2009; Kuyper & Fokkema, 2011; Denton, Rostosky, & Danner, 2014). Using patient-reported data from an English national survey of 2,169,718 respondents, Elliot et al. (2015) found that sexual minorities are more likely to report physical and mental health difficulties than same-gendered heterosexual people. Other evidence indicates that there is more risk for suicidality for sexual minorities than their heterosexual counterparts (Meyer, 2013; Irish et al., 2018). Identifying as a sexual minority is also linked to increased risk for self-injurious behaviour (Balsam, Beauchaine, Mickey, & Rothblum, 2005), substance abuse (DiPlacido, 1998) and physical health difficulties (Durso & Meyer 2013; Meyer, 1995, 2003; Ross, 1990). This could explain why more sexual minorities use mental health services than heterosexual people (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000).

### **2.1.3. Feminist Theory**

Feminist theory can also be used to understand the impact of heterosexism on sexual minorities (Brown, 1994; Rostosky & Riggle, 2002; Szymanski, 2005, 2006). Szymanski, Kashubeck-West and Meyer (2008) clarified that "many of the problems experienced by persons with limited power in society can be conceptualized as reactions to oppression" (p. 513). The Feminist notion that 'the personal is political' can account for the negative impact a patriarchal and heterosexist society can have on not just one but many oppressed populations, including sexual minorities (Parritt, 2016). Feminist theory emphasises the significance of analysing the function of oppression (Brown, 1994). Disproportional power dynamics in society preserve the status quo of only a privileged group of people. Questioning this status quo and advocating for equal rights can be perceived as dangerous by people who feel threatened by the concept of equality and, therefore, respond with hostility towards it. This can leave the disadvantaged people socially and psychologically

injured (Ryle, 2012). According to Feminist theory, healing is possible through an egalitarian relationship (Brannon, 2016; Szymanski, 2005), and the involvement in a community that offers affirmation and positive role models (Szymanski et al., 2008).

Both Minority Stress and Feminist theories agree that psychological distress is the result of external and internalized experiences of rejection, discrimination, stigma and abuse from the social, cultural and economic context within which one exists (Szymanski, 2005). Nonetheless, both theories seem to miss the potential impact of early developmental factors that could shape how a person perceives or internalises subsequent rejecting messages about oneself. For example, people are more likely to perceive their social surrounding as rejecting, unfair and not trustworthy if they have been exposed to early childhood experiences of interpersonal trauma. These could be abandonment, emotional/physical neglect and abuse by their carers (Van der Kolk, 2017).

#### **2.1.4. *Discrimination in Mental Health***

The phenomenon of discrimination against gay men varies across time and cultures. Some evidence suggests that, at least for men, same-sex relationships were accepted in ancient Greece (Fassinger, 1991). A 1951 survey of global sexual practices indicated that 64% of cultures considered same-sex relationships as appropriate (Atkinson & Hackett, 1998). However, same-sex relationships in these contexts were mostly understood in terms of sexual behaviours. Several authors (e.g., Scrivner, 1997 Ginicola, Smith, & Filmore, 2017) use the term affectional orientation, as opposed to sexual orientation, to indicate the romantic and affectionate elements of same-sex relationships. It is difficult to estimate accurately the level of discrimination against gay men when the expression of these elements is not taken into account.

Societal intolerance and discrimination toward sexual minorities in Western culture has been shaped by Western religious views in medieval times (Fassinger, 1991). Inevitably, the field of psychology has also been impacted by these religious and social ideas (Atkinson & Hackett, 1998). Consequently, being a sexual minority was given a pathologising meaning which perpetuated discrimination against gay men (Morin, 1977). In fact, same-sex attraction was considered to be a mental illness up until 1973 (Bradford, Ryan, & Rothblum, 1994; Baron 1996). Not surprisingly, no empirical research was involved for early diagnostic conceptualisations (Morin, 1977).

Psychoanalytic thinking was the established orientation for understanding mental health when the *Diagnostic and Statistical Manual (DSM)* for mental disorders originated and “homosexuality” was classified as a “sociopathic personality disturbance” (Herek & Garnets, 2007, p. 356). Freud’s theories on sexuality described same-sex attraction as a rather

benign developmental arrest (Herek & Garnets, 2007). It was only post-Freudians who decided that, unlike heterosexual attraction, same-sex attraction was pathological (Herek & Garnets, 2007) and proposed theories of aetiology and 'treatment' (Eubanks-Carter, Burckell, & Goldfried, 2005). Such treatment often comprised efforts to "cure" the 'problematic sexual orientation' (Herek & Garnets, 2007). *DSM II* reclassified "homosexuality" as sexual deviance. It was then when mental health professionals and advocates started arguing for the removal of same-sex attraction from diagnostic manuals (Eubanks-Carter et al., 2005). This was encouraged by Kinsey, Pomeroy, and Martin's (1948) research indicating that same-sex sexual behaviour was more common than once speculated (Fassinger, 1991). Furthermore, Hooker's (1957) psychological testing indicated no differences in pathology between matched samples of people with opposite- and same-sex attraction (Herek & Garnets, 2007). Although the American Psychiatric Association removed "homosexuality" from *DSM II* in 1973 (Baron 1996), "homosexuality" was replaced by "sexual orientation disturbance" for individuals "in conflict with" their sexual orientation. It was not until 1987 that same-sex attraction was completely removed from *DSM-III-R*, the revised version of *DSM-III* (Silverstein, 2009).

Even with his benign approach, Freud contradicted himself when proposing his theory of universal and innate bisexuality (1905/1962) as he referred to homosexuality as "inversion". Such a term was used by sexologists of his time (Miller, 1995). However, unlike post-Freudians (Herek & Garnets, 2007), Freud himself (1921/May 1977) encouraged the inclusion of qualified homosexual applicants to psychoanalytic training institutes and supported the idea that homosexuality is not an illness (1935/1951). Several contemporary psychoanalysts (e.g., Malyon, 1982/1995; Izzard, 2000) proposed a psychodynamic gay-affirmative psychotherapy. Newbigin (2013) noted, however, that not all members of the British Psychoanalytic Council (BPC) welcomed the BPC's position statement in 2012 that: "the BPC does not accept that a homosexual orientation is evidence of disturbance of the mind or in development" (p.276).

Psychoanalysis is not the only approach that traditionally espoused heteronormative beliefs. For example, techniques such as aversion therapy and systematic desensitisation using emetics and electric shocks based on behavioural approaches have been used in the past to 'change' one's attraction (see Barlow, 1973). Cognitive Behavioural Therapy (CBT) has its roots in the rational emotive therapy (RET), later termed as Rational Emotive Behavioural Therapy (REBT). Ellis (1956), the father of RET, proposed that homosexual behaviour was the result of irrational and self-defeating beliefs, which had to be challenged. However, he subsequently revised these notions (Dryden & Neenan, 1995). Furthermore, important CBT

pioneers (e.g., Padesky, 1989; Ross, Doctor, Dimito, Kuehl, & Armstrong, 2007) later suggested the use of CBT to reinforce a positive LGBT identity.

Humanistic therapy has not been an exception in homophobic practice. Boss (1949), an existential phenomenologist, saw homosexuality as a perversion. However, Cohn (1997) explained that such a view is unacceptable from an existential position, as it is rather “unphenomenological” (p.90). Moreover, while the American Psychiatric Association was classifying “homosexuality” as an illness, Carl Rogers, the developer of the Person-Centred approach (PCA), “made no distinction about, nor placed any judgments on the gay experience, reinforcing gay life as a potentially satisfactory and acceptable way of being” (Knopf, 1992, p. 52). Rogers’ discard of pathology, his non-judgmental attitude and his ‘prizing’ of individuals for who they are offered many sexual minority therapists and clients a safe haven in the PCA (Davies, 2000). Still, only later the topic of same-sex attraction and sexuality was given more attention by the Person-Centred literature (Davies, 1998; Knopf, 1992; Schmid, 1996). Lemoire and Chen (2005) urged that, unlike the non-directive PCA, clinicians might need to be explicit in validating and normalising the identity and feelings of their sexual minority clients.

### **2.1.5. Affirmative Therapy**

The removal of “homosexuality” as a diagnostic category in 1973 signalled the change of the social outlook on same-sex attraction in the mental health field. Such a change encouraged the emergence of what was termed as 'lesbian and gay affirmative psychotherapy' and then referred to as 'affirmative therapy' (Milton, Coyle, & Legg, 2002). Affirmative therapy appeared essential following numerous reports of negative therapeutic experiences by lesbians and gay men (Garnets et al., 1991; Proctor, 1994; Golding, 1997; Annesley and Coyle, 1998; McFarlane, 1998; Milton and Coyle, 1998). Amongst several models, Malyon (1982/1995) proposed a stage model for gay affirmative therapy and Domenici and Lesser (1995) drew on postmodern theories, such as Social Constructivism and Queer Theory, to critique conventional models of psychoanalysis. In the UK, Pink Therapy (see [www.pinktherapy.com](http://www.pinktherapy.com)) is the leading independent therapy organisation specialising in working therapeutically with gender and sexual diverse clients.

Although the term ‘affirmative therapy’ is described differently across the literature (Harrison, 2000), it generally describes therapy that asserts the status of a sexual and gender minority identity as equal with the dominant sexuality/gender position. Such practice is “informed by appropriate knowledge of minority communities, their diversity and specific needs” (British Psychological Society, 2012a, p.70). It also involves the formation of a therapeutic relationship defined by acceptance and understanding (Johnson, 2012). These definitions

are consistent with the updated Code of Ethics and Conduct by the British Psychological Society (2018) which emphasises the virtue of “respect” when working with people “regardless of perceived or real differences in social status, ethnic origin, gender, capacities, or any other such group-based characteristics. This inherent worth means that all human beings are worthy of equal moral consideration” (p.5). However, du Plock (2014) critiqued ‘affirmative therapy’ for encouraging the therapist to take an authoritative position with the client. He urged that such an “expert” position might counteract the therapist’s ability to value, give space to and work with difference.

*Queer Theory* has also impacted the way we understand and approach sexual minorities in psychotherapy and research. With its postmodernist views, Queer Theory challenges the modern essentialism and its ‘binary’ conceptions of sex and gender (Ryle, 2012). It aims to “render it evident that neither gender nor sex is a natural category-indeed, the very idea of a “natural” category is simply an effect of discourse” (Alsop, Fitzsimons, & Lennon, 2002, p.106). Furthermore, Queer Theory challenges traditional psychoanalysis and other modernist approaches that are linked to socially constructed identities, patriarchy, misogyny and heteronormative practice (Ryle, 2012). As such, the therapist/researcher embraces the idea that identities are not necessarily fixed, allowing space for complexity and depth. However, Balick (2010) argues that strictly replacing a heterosexist ideology with a postmodern or queer one may still imply an essentialist view of prizing a given sexual identity over another. Balick (2010) suggests an approach where the focus is on the unconscious and intersubjective processes involved in the co-construction of identities. As such the focus is not on whether there are fixed or fluid identities but on the multiple and co-created identities, replacing the political and radical ‘challenge’ with an open co-creation.

Langdridge (2014) distinguished between *ethically affirmative* and *LGBQ affirmative therapies*. Whereas the ethically affirmative practice accounts for the equal treatment of sexual minority and heterosexual identities in therapy, LGBQ affirmative therapy involves a more active affirmative stance of the client’s same-sex thoughts and feelings. However, both stances require sensitivity to cultural diversity. Langdridge (2014) challenged the idea that therapists should aim to remain neutral when working with sexual minority clients. He clarified that such neutrality may not be possible, as therapists inevitably disclose themselves throughout the therapeutic process. Also, neutrality may even silence experiences and needs specific to sexual minority individuals. Langdridge (2014) suggested that therapists focus on the phenomenology of the client and inform their work from Ricoeur’s (1970) *demythologising* (or empathic) and *demythifying* (or suspicious, deep examination of meanings) approaches. This can help clients unpack the multi-layered meanings of their sexual identity and reach a better understanding and acceptance of it.

### **2.1.6. Current Issue**

Nowadays, the construct of the clinical and counselling competency when working with sexual minorities is being used to combat the current and historic biased views that stigmatised these individuals as mentally ill, immoral, inferior, or socially deviant (American Psychological Association, 2009; 2012; British Psychological Society, 2012a, 2012b; UKCP, 2017). Milton (September, 2017) urged psychologists, practitioners and researchers to be mindful of the impact of social injustice and inequality, and of the damage when not tackling harmful policies and practices. However, recent literature suggests that sexual minorities in therapy may still experience discrimination and biased practice (Bowers, Plummer, & Minichiello, 2005; Greene, 2007; Bidell, 2012, 2014; McGeorge, Carlson, & Toomey, 2013; O'Shaughnessy & Spokane, 2013). Furthermore, there is much evidence that some therapists might still use a heterosexist frame of reference, view same-sex attraction as a disorder and attribute all presenting difficulties to one's sexual orientation (Bartlett, King, & Phillips, 2001; Bieschke, Paul, & Blasko, 2007).

A recent national survey in the UK showed that 2% of LGBT individuals have undergone conversion therapy and another 5% have been offered it (Government Equality Office, 2018a). This is ethically concerning, as conversion therapy is linked to depression and suicidality (Ryan, Toomey, Diaz, & Russell, 2018). Moreover, research in favour of conversion therapy has been found to have significant methodological flaws regarding definitions and measures of "heterosexuality" (Bieschke et al., 2000; Haldeman, 2002; Morrow & Beckstead, 2004) and it has been noted that the majority of clients attending it do not report changes in their sexual orientation (Shidlo & Schroeder, 2002). Furthermore, research investigating the harm or helpfulness of this kind of therapy indicates a significant harm, urging that conversion therapies are unethical practices (Bieschke et al., 2007). People might seek conversion therapy because of their internalised heterosexism and confusion around their sexual/affectional identity development (Tozer & Hayes, 2004). The power of the therapist can be used unethically to impose values on these individuals either towards or against a specific sexual identity (Beckstead & Israel, 2007; Drescher & Hellman, 2005). In fact, the American Psychological Association and the British Psychological Society have issued strong position statements condemning conversion therapies as unethical and harmful for sexual and gender minority clients (American Psychological Association, 2009, 2012; British Psychological Society, 2012a, 2012b). Lago and Smith (2010) urged that although the experience of SIGM and other sexual minority clients nowadays may no longer be of therapists attempting to "cure" them, therapists need to work through their own unconscious biases in order to work therapeutically with such individuals.

Discriminatory experiences can be harmful for clients in therapy because of their vulnerability and the therapist's position of power. Moreover, biased practices can block the presence of therapeutic empathy which is often described as essential for the client's therapeutic progress (McHenry & Johnson, 1993; Mearns, Thorne, & McLeod, 2013). It is likely that sexual minority clients have already experienced prejudice prior to engaging in therapy, something that can make them even more sensitive to the therapist's bias (Fell, Mattiske, & Riggs, 2008). Even subtle microaggressions can make clients feel misunderstood and want to drop out of therapy (Constantine & Sue, 2007; Dorland & Fischer, 2001; Sue, 2010). Sexual minorities are more likely to use mental health services than their heterosexual counterparts (Cochran, Sullivan, & Mays, 2003). It is therefore essential that psychotherapy research focus on addressing and lessening experiences of discrimination in therapy.

## **2.2. Client Experiences of Therapy**

### **2.2.1. *Research on Therapy Experiences***

A great amount of studies and meta-analyses show therapy to be beneficial (Lambert & Ogles, 2004), regardless of the therapeutic modality (Elkin et al., 1989; Norcross, 2002; Norcross & Wampold, 2011). However, therapy can also be experienced as unhelpful by clients (Bowie, McLeod and McLeod, 2016; Grafanaki & McLeod, 1999; Paulson, Everall, & Stuart, 2001; Swift, Tompkins, & Parkin, 2017; von Below & Werbart, 2012). Though not always defined by research, 'hindering' or 'unhelpful experiences' of therapy are often described by clients as interferences to their process of therapy that stop them from achieving their goals (Henkelman & Paulson, 2006).

According to Elliott (2008) the investigation of client experiences in therapy is essential in order to enhance our understanding of the mediational processes involved in therapeutic change. This can help therapists understand particular clients and work more effectively with them. The issue of unhelpful therapy has been a focus of interest for long time in the field of counselling and psychotherapy (Bergin, 1963; Binder & Strupp, 1997; Bowie, McLeod, & McLeod, 2016; Grunebaum, 1986). This is becoming more relevant when records show clients indicating more negative than positive therapy outcomes (Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011). It can be difficult for therapists to recognise when therapy is not helpful for a client (Hatfield, McCullough, Frantz, & Krieger, 2010; Stewart & Chambless, 2008). Consequently, researchers and therapists are contemplating ways to tackle the issue of unhelpful therapy experiences (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010).

Historically, most of the research on clients' experiences in therapy has been informed by the therapists' and researchers' accounts rather than the clients' (Ward, 2000). However, Duncan and Moynihan (1994) urged that it is clients themselves we need to hear from in order to deepen our understanding of their experiences and to direct the course of therapy appropriately. Large-scale studies and Randomised Controlled Trials (RCTs) have been used to identify wide categories of unhelpful therapy. However, these methods have used only symptom deterioration at the end of therapy as an indicator of unhelpful therapy (Lilienfeld, 2007). Such a method can miss other variables and processes that may be involved in unhelpful therapy experiences, such as the quality of the therapeutic relationship (Carey & Stiles, 2016; Shean, 2015) and how the clients perceived and were affected by different events that took place during therapy. It is important, therefore, to supplement findings of large scale and RCT studies by enquiring about clients' perceptions of unhelpful experiences on a level deeper than symptom reduction. This is particularly relevant considering that clients can find it hard to feed back dissatisfaction to their therapists (Levitt, 2002), something that can lead to harmful utilisation of the therapist's power (Armstrong, 1990; Bates, 2006; Dale, Allen, & Measor, 1998; Frenken & van Stolk, 1990).

Some of the first research on client experiences of therapy was within the Person-Centred field by Lipkin (1948). According to Elliott (2008) in the literature one can find *events-based*, *qualitative mental health service evaluation* and *quantitative survey predictor* studies. *Qualitative mental health service* studies have shown helpful experiences to involve a supportive therapeutic relationship (e.g., Mörtl & Von Wietersheim, 2008), the therapist being attentive, validating and empathic (e.g., Israel, Gorcheva, Burnes, & Walther, 2008) and the therapist providing certain techniques for managing difficulties (e.g., Israel et al., 2008). Conversely, unhelpful experiences involved the therapists imposing their views on the clients and being judgmental and invalidating (e.g., Israel et al., 2008). Such findings are consistent with older (e.g., Elliott & James, 1989; Grafanaki & McLeod, 1999) and more recent (e.g., Bowie, et al., 2016; Paulson, et al., 2001; Swift, et al., 2017; von Below & Werbart, 2012) qualitative studies on the unhelpful experiences of clients in therapy. However, most of these studies included participants from the general population.

When most therapy research involves primarily the general population, the experiences of specific populations, such as sexual minorities, is silenced and can sometimes reinforce a pathologising view for these clients (Davies & Neal, 2000). Counselling Psychology considers such power dynamics in research and their impact in therapy and the wider society (Douglas, Woolfe, Strawbridge, Kasket, & Galbraith, 2016; Milton, 2010; Toporek, Gerstein, Fouad, & Israel, 2006). Shelton and Delgado-Romero (2011) clarified that homonegativity and heterosexism are often manifested in subtle forms of discrimination, also



termed as microaggressions, in therapy. Such microaggressions are difficult to identify or talk about (Shelton & Delgado-Romero, 2011). This can add a specific layer of an unhelpful experience in therapy for sexual minorities that may not show in research on the general population.

### **2.2.2. *Why Research Unhelpful Experiences in Therapy?***

Research on helpful and unhelpful experiences of therapy can encourage effective therapeutic practice (Carkhuff, 2017; Elliott, 2008). As discussed above, therapists can find it difficult to know when therapy is unhelpful for clients (Hatfield et al., 2010; Stewart & Chambless, 2008) and clients themselves may struggle to talk about unhelpful incidents in therapy (Levitt, 2002; Shelton & Delgado-Romero, 2011). This can result in harmful therapy experiences (Bowie et al., 2016). Some clients report an increased deterioration of their mental health following therapy and it is difficult to attribute this to the type of therapy itself (Lambert, 2013). Yet, there is only very little research investigating the negative or unhelpful experiences of clients in therapy (Crawford et al., 2016) and often these studies have focused on specific mental health presentations (Holding, Gregg, & Haddock, 2016) and on the general population.

### **2.2.3. *Why Focus on SIGM Clients?***

As discussed above, compared to heterosexual individuals, sexual minorities present a higher prevalence of mental health difficulties, such as depression, anxiety and substance abuse (Chakraborty, McManus, Brugha, Bebbington, & King, 2011; Cochran, Sullivan, & Mays, 2003; McCabe, Hughes, Bostwick, West, & Boyd, 2009). However, sexual minority clients in Western societies may still report implicit and explicit homophobia in therapy (Bowers et al., 2005; Shelton & Delgado-Romero, 2011) and in health care in general (Mimiaga, Goldhammer, Belanoff, Tetu, & Mayer, 2007). Some healthcare providers even report feeling uncomfortable providing services to sexual minorities (Smith & Matthews, 2007). It is for these reasons the healthcare and mental health of sexual minorities have recently been identified as priority areas for research in the US (Graham, et al., 2011), and the Government's Equality Office (2018b) in the UK has urged for an Action Plan that focuses on the mental health of sexual minorities.

In the early 2000s, even as gay-affirmative approaches were increasingly incorporated (Kilgore, Sideman, Amin, Baca, & Bohanske, 2005), SIGM and other sexual minority clients would often experience discrimination and hostility in therapy (Bowers et al., 2005; Greene, 2007; Bieschke et al., 2007). Unhelpful experiences involved ignorance or hostility to sexual minority-related issues by therapists, leaving clients feeling stereotyped or misunderstood. However, in their systemic review, King, Semlyen, Killaspy, Nazareth and Osborn (2007)

discussed the possibility of this changing over time due to the increased awareness around same-sex attraction. Nowadays, following the statements by the British Psychological Society (British Psychological Society, 2012a; 2012b; Shaw, et al., 2012), the American Psychological Association (APA, 2009; 2012) which updated the guidelines for psychologists working therapeutically with sexual and gender minority clients, and the Consensus Statement (UKCP, 2014) opposing 'Conversion Therapies', as well as significant changes in the law, such as the Marriage (Same Sex Couples) Act (2013), one would hope that therapists embrace Affirmative Therapy and that negative or unhelpful experiences of gay men in therapy may no longer be related to discrimination. However, as Johnson (2012) argued, it would seem that there is no real theoretical framework, operational definition, or outcome measures for Affirmative Therapy. Thus, Counselling Psychologists and other practitioners may feel uncertain as to how to incorporate it into their practice and how to investigate it in research. Accordingly, sexual minority clients may still be exposed to unhelpful experiences around their sexual identity in therapy.

A recent survey in the UK by Crawford et al. (2016) indicated that non-heterosexual clients were more likely than heterosexual clients to report negative effects of therapy. Recent studies also suggest that clinical services lacking the competency to work with gay individuals could negatively impact these clients' experiences and clinical outcomes (Institute of Medicine, 2011) and their health-care provision satisfaction compared to their heterosexual counterparts (Elliott et al., 2015). This suggests that mental health services need to develop competency in working with sexual-minority clients (Bidell, 2016).

All the above mentioned arguments and literature imply the need for further and deeper up-to-date research to explore the unhelpful experiences of sexual minorities in therapy. In scientific research, focusing on specific clients (i.e., SIGM), thus aiming for a *purposive sampling*, could help the greater and deeper understanding of the phenomenon of interest (Etikan, Musa, & Alkassim, 2016). The author of this thesis adopts a *Hermeneutic Realism* ontology (Slife & Christensen, 2013) which assumes that our experiences can be influenced by the meanings of and relationships we have with various phenomena. Thus, in line with *Stress Minority* and *Feminist* theories, sexual minorities of different genders may have different meanings of and relationships with experiences of discrimination that can affect how they experience unhelpful and discriminatory incidents in therapy. The fact that this study will employ an *Interpretive Phenomenological Analysis* (IPA) makes it even more necessary to focus on as homogeneous as possible a population (Willig, 2013). Accordingly, the literature review below will maintain its focus on the experiences of SIGM clients.

### **2.3. Research on Unhelpful Experiences of SIGM in Therapy**

Several studies in the past have focused on helpful experiences of SIGM and other sexual minorities in therapy. For example, in his phenomenological study, Lebolt (1999) interviewed nine gay men who described supportive and affirmative therapy experiences in relation to their sexual orientation. Helpful experiences for SIGM were also reported in Pixton's (2003) Grounded Theory study. Amongst the various themes and categories that emerged, these two studies highlighted SIGM clients' need for an accepting and validating relationship with their therapists. Nel, Rich and Joubert (2007) combined a quantitative and qualitative study with SIGM participants who had previously engaged in an affirmative group therapy setting in South Africa. This study also illuminated the helpful impact of the affirmative and supportive therapeutic relationships on SIGM clients. However, the quantitative analysis indicated that a small percentage of the participants did not agree that their therapy had been a positive experience. Yet, Nel et al. (2007) did not explore this finding further. As Henkelman and Paulson (2006) have argued, participants are more likely to talk about helpful incidents in therapy. Consequently, knowledge about what is hindering or unhelpful tends to come only from inferences through the researcher. The little existing research shedding light on unhelpful experiences will now be explored.

#### **2.3.1. Quantitative Research**

RCTs are often considered the 'gold standard' when testing psychotherapy efficacy (Johnson, 2012). Such clinical trials are typically used to study the efficacy of different medications. The need for a methodology to test the difference between psychotherapy and psychotropic medication has encouraged the use of RCT (Blais & Hilsenroth, 2007). RCT approaches can be robust and have high internal validity. However, they are criticised for encompassing restrictive inclusion criteria and unrealistic treatment comparison groups (Blais & Hilsenroth, 2007). These can decrease the external validity/generalisability of the findings (Johnson, 2012). As such, it has been argued that RCT are not able to explore the complexity inherent in therapy (Norcross, 2002; Westen, 2007; Westen, Novotny, & Thompson-Brenner, 2004).

For this reason, Johnson (2012) discussed how conducting RCTs with sexual minorities could have methodological and ethical limitations, such as a sample of clients not being representative of all the sexual minority communities and controlled structured interventions being offered to a 'treatment group' but not to a 'control group'. Johnson (2012), therefore, argued that psychotherapy research employing RCTs would offer findings of little usage for clinical practice. Furthermore, as mentioned above, it has been argued that RCTs cannot explore the role of other important variables in the therapeutic process, such as the

therapeutic relationship (Blais & Hilsenroth, 2007; Clark, 2009; Goldfried & Davila, 2005; Norcross, 2002). These arguments can explain why RCTs have not been the preferred method in studying the experiences of SIGM clients in therapy.

Still, the use of RCTs could illuminate important information regarding the topic of interest. Crawford et al. (2016) analysed data from the National Audit of Psychological Therapies to identify the prevalence of client-reported negative effects of therapies and the factors impacting their likelihood. The audit consisted of an evaluation of routine clinical records based on agreed standards of care and a survey that was filled out by over 15000 clients with depression and anxiety using different primary and secondary care services in England and Wales. These clients were provided therapies defined by the National Health Service as CBT, Cognitive Analytic Therapy (CAT), Counselling, Humanistic therapy, Solution-Focused Therapy (SFT), Psychodynamic therapy or Low-intensity therapy, and as individual or group therapy. The results of this study showed that sexual minority participants were more likely to report 'lasting bad effects' than heterosexual participants. Qualitative data about negative effects were not collected in the survey, so it was not possible to gather more details about these negative experiences. However, subsequent data from in-depth interviews of participants who reported negative experiences suggested that their negative experiences aggravated their existing symptoms and even evoked new ones, such as anxiety, anger and loss of self-esteem.

Crawford et al. (2016) obtained the survey data from clients who were still in or had recently completed therapy. Thus, it is not clear whether these clients had time to resolve the negative incidents with their therapists or to subsequently understand them in a different way. Moreover, some clients reported that the term 'negative' could not account for how difficult their experiences had been. Such limitations could have been managed by a complementary qualitative research. Still, the findings by Crawford et al. (2016) are consistent with previous studies (King, et al., 2007) raising concerns about discriminatory practice in therapy for sexual minorities.

A systematic review by King et al. (2007) of all 25 studies on sexual minorities and therapy that existed then shed light on noteworthy findings that could still be relevant. For example, a study by Jones, Botsko and Gorman (2003) based on a survey completed by 600 current or former sexual minority clients showed a prediction for better outcomes from therapists trained as social workers or psychologists rather than psychoanalysts. This could perhaps be understood in terms of the homophobic history of psychoanalysis discussed above. The same study showed that therapists' attempts to change one's sexual orientation in therapy were linked to worse therapy outcomes. To indicate how beneficial therapy was, the

participants of this study had to respond to a 10-point scale extending from 1 (*very destructive*) to 10 (*very beneficial*). Thus, similar to the study of Crawford et al. (2016), this study could not elaborate much on the less beneficial experiences of therapy. Qualitative methods could provide a deeper understanding of the less beneficial or unhelpful experiences of sexual minorities in therapy.

There was very little focus on the unhelpful experiences of SIGM clients in therapy reported by King et al. (2007), and, indeed, that came mostly from qualitative studies. These studies will be explored below alongside other or more recent relevant research.

### **2.3.2. Qualitative Research**

In the UK, Mair and Izzard (2001) used Constant Comparative Analysis (CCA) to explore potential difficulties that 14 gay men had experienced in therapy. CCA is a technique used in the development of grounded theory which involves the iterative and inductive process of reducing the data through constant recoding (Willig, 2013). In this study, many participants expressed that their therapist could not understand what it meant to be gay and its impact on their personal development. As such, participants felt 'unseen' and 'not understood'. Therapists' ignorance of 'gay matters' and specific language was reported to be highly disruptive to the therapeutic alliance, resulting in feelings of being discriminated or stuck in therapy. Additionally, the therapist was described as someone who could not help them explore their sexual identity adequately. Participants reported that they expected a more proactive approach from their therapists to embrace and explore their sexual identity. They expressed frustration and anger at the fact that their sexuality had not been discussed.

Mair (2003) identified some 'discrepancy' in the responses of the participants in Mair and Izzard's (2001) study. For example, some participants described having a gay therapist as unhelpful, as they feared they would not give them space to explore the fluidity of their sexuality. Then again, some wanted to work with a gay therapist. These participants expressed engaging in self-censoring when working with an assumed heterosexual therapist. Perhaps, this 'discrepancy' can show how different clients may perceive different things as unhelpful or helpful in therapy. Indeed, Mair (2003) stated that the findings of Mair and Izzard's (2001) study indicate that different clients and therapists may understand 'Gay Affirmative' therapy very differently.

Some participants in Mair and Izzard's (2001) study were interviewed via phone. Face to face interviews might have elicited different experiences from participants (Sturges & Hanrahan, 2004). Furthermore, the interview was structured and, thus, might have limited a

deeper exploration. Also, the participants were asked to rate their therapy experience on a scale of 1-5, with 1 being 'Very helpful' and 5 being 'Unhelpful'. This quantitative method is not as suitable as an explorative qualitative method to capture the issue in depth. Perhaps a phenomenological approach could have been more suitable to explore and understand the lived unhelpful experiences of these individuals in therapy beyond the descriptive level than CCA had provided.

Another limitation of this study is that the duration of the participants' therapy varied from six sessions to twelve years. Previously, research has shown that the longer the therapy was the more likely clients would be to experience their therapists positively (Jones & Gabriel, 1999). Different session numbers could imply that either the clients had such a negative experience that it led to an earlier termination or that they were not provided with a sufficient amount of sessions to explore their concerns further. Participants also had a wide age range. This could imply different stage of coming to terms with one's sexual identity. The level of distress or comfort in identifying as a gay individual could have influenced the experience of therapy (Jones, Botsko & Gorman, 2003). It is also unclear whether participants were facing any other mental health difficulties that could have impacted their recall of experiences.

In the USA, Waehler (2008) also used CCA and Likert questions to explore the factors that can be unhelpful or potentially harmful to six lesbian women and six gay men in therapy. She took this exploration further by additionally assessing the resiliency factors that helped them recover from these negative experiences. Unlike Mair (2003), she explicitly clarified that participants who, for medical or mental health reasons, had their memory or cognitive functioning impaired could not participate in the research, to aim for more accurate accounts.

Here participants' unhelpful experiences in therapy involved incidents in which their therapists committed professional and ethical violations, such as breaking confidentiality and having inappropriate boundaries with clients, as well as disregarding their sexual identity. In line with previous (e.g., Liszcz and Yarhouse, 2005) and recent (e.g., Bidell, 2014) research, these explorations also seem to suggest that religiously affiliated psychologists are less likely to endorse gay-affirmative approaches to therapy. As a result of unhelpful experiences, participants reported engaging in self-destructive behaviours, such as over-eating, socially withdrawing or failing to attend work/school.

Thus, CCA illuminated that gay men and lesbian women presented similar themes of what unhelpful experiences in therapy entailed. Nonetheless, they appeared to differ in patterns of

emotional experiences. For example, fewer men disclosed experiencing anger and confusion compared to women. This suggests the suitability of exploring the subjective experience of this population in homogenous samples in order to aim for richer and deeper understandings. By using Likert questions, this study has also limited the richness and depth of further and deeper explorations. Waehler's (2008) participants had an age range between 21-41, diverse education and, similar to Mair's (2003) participants, different session numbers. These limited further the homogeneity of the sample. This study also presumes that gay individuals' unhelpful experiences in therapy may only happen with heterosexual therapists. However, previous research indicated that therapists with a LGB identity may also be involved in unhelpful therapy experiences with sexual minority clients (e.g., Morrow, 2000), and that therapists of any orientation could be experienced as helpful when behaving in ways that are perceived as supportive of the client's gay identity (e.g., Lebolt, 1999).

Waehler's study explored resiliency after the unhelpful experience of therapy; resiliency in non-majority sexualities has not been a focus of research (e.g., Negy & McKinney, 2006). Gay men have been considered to be resilient, due to having to develop coping strategies to gain both personal and societal acceptance (Russell & Richards, 2003). In therapy, such knowledge could provide a strength-based perspective of resiliency and enable therapists to help clients view themselves as courageous survivors instead of helpless victims (Miller, 2003). Indeed, Waehler (2008) illuminated that many participants found hope from within or from their support network to overcome these incidents. Future studies on unhelpful experiences of gay men in therapy could do further exploration on how people coped. This could be useful in helping us understand the underlying mechanisms of these coping strategies and their subjective meanings and functions, in order for therapists to be more useful to this population.

Bowers et al. (2005) in Australia employed theoretical sampling, a key strategy often used in Grounded Theory research (Willig, 2013), in order to examine both client and therapist narratives on homophobia in therapy. Thirty-four adults participated in this study, of which sixteen were therapists and eighteen clients (four gay, six lesbian, four bisexual and four transgender individuals). The client participants were provided with a space to discuss any issues linked to their past therapy interactions. The therapist participants were asked about their experiences of working therapeutically with sexual minorities. The data were coded based on the identified themes across all participants and with a focus on the themes initiated by the client participants. Similar to the studies mentioned above, Bowers et al. (2005) identified certain unhelpful or homophobic therapists' behaviours and traits, such as biased assumptions, prejudice and lack of knowledge on sexual minority matters. Many

client participants described social interactions that took place in therapy and were linked to their sexual orientation as difficult and traumatic and making them feel socially isolated. Interestingly, based on their findings, the authors noted that discriminatory social interactions may not always be obvious, but rather subtle and complex. This can show how difficult it may be for both clients and therapists to notice when such unhelpful interactions take place during therapy.

This research has the advantage of including both the perspectives of therapists and clients. However, the therapists that were interviewed were not the same therapists that the client participants had during their negative experiences. Therefore, it is difficult to evaluate how the two perspectives link. Furthermore, some client participants only had a single session of therapy. This could have limited the breadth and depth of knowledge about the impact of the unhelpful experience on their relationship with their therapists and their overall therapeutic process and progress.

In the USA, Israel et al. (2008) used Ethnographic Content Analysis (ECA) and identified patterns of unhelpful situations that clients experienced in therapy. Participants were 42 lesbian, bisexual, gay, trans and gender-queer (a term to express a fluid, or unique gender, gender expression, or gender transgression; Fassinger & Arseneau, 2007) individuals of whom 12 were gay men. Unhelpful experiences that participants commonly described included therapists judging, invalidating, or misunderstanding them and failing to create a connection with them. Unhelpful experiences were likely to involve the therapist being experienced as cold, disrespectful, disengaged, distant or uncaring. These experiences would typically impact negatively upon the therapeutic relationship (e.g., evoke clients' feelings of dissatisfaction, rejection, betrayal, frustration, hopelessness) and often result in clients not disclosing or exploring concerns, a negative impression of therapy in general, a negative impact on client's sexual orientation/gender identity development or coming out and/or termination. Unhelpful situations were also reported to result in clients' damaged quality of life (e.g., no progress in therapy, more symptoms, damaged relationships, decreased self-acceptance). Interestingly, several participants in the Israel et al. (2008) study reported that their therapists had a positive stance towards their sexual orientation in unhelpful situations, such as when the therapist focused more on sexuality than the client wanted.

It is worth noting that the unhelpful experiences presented by this research were not always related to the sexual orientation of the participants. For example, the findings included unhelpful practises, such as the therapist dismissing the clients' grief or urging them to complete their college education contrary to their wish. Moreover, the lack of homogeneity of



the sample might have masked individual differences around the unhelpful experiences. Furthermore, participants reflected on events in therapy from as far as 40 years prior to their participation in the study. Thus, it is difficult to know whether such retrospective recall held memory biases. The findings of Israel et al. (2008) also indicated that therapists often expressed positive responses towards clients' sexuality in the unhelpful situations. It is unclear from the study how a positive response can be unhelpful. However, it can indicate that therapists may still communicate discrimination, not overtly, but on an implied/micro level, regardless of whether they claim to be inclusive. Perhaps a phenomenological analysis could be suitable to elicit clients' voices about these rather multi-layered unhelpful experiences to explore the context, meaning and impact on a deeper level.

More recently, Quiñones, Woodward & Pantalone (2017) in the USA explored the experiences reported by 77 sexual and gender minorities using directed content analysis. Directed content analysis is similar to Grounded Theory, though it differs in its philosophical underpinnings, methods and aims (Cho & Lee, 2014). Quiñones et al. (2017) sought to obtain findings that could enhance the understanding of competent therapy practice with sexual minority clients.

The findings of this study revealed several 'positive', 'negative', and 'neutral' therapy experiences. 'Positive experiences' included validation, active listening and *Socratic questioning*. However, these examples are very general and may not account just for sexual minority clients. In terms of sexual orientation specifically, the participants reported as 'positive' when the therapists addressed their sexual identity only when relevant and when therapists had knowledge about sexual minority matters. Negative experiences included the therapist being stereotypical or mentioning the client's sexual orientation when not relevant.

These findings can be useful in developing categories for potentially helpful therapeutic practices for SIGM and other sexual minority clients. However, they lack depth as they do not show *how* these 'negative' practices were experienced by the clients. Moreover, the sample consisted of individuals identifying as *male*, *female* or *genderqueer*. Thus, the findings cannot indicate whether different genders experienced therapy differently or when the stereotyping was possibly linked to the gender identity of the participants. Similar to the studies mentioned above, a phenomenological study could help bridge these gaps.

With therapists gaining more awareness about sexual minorities and refraining from overt forms of discrimination in the USA, Shelton and Delgado-Romero (2011) used phenomenological analysis (PA) to explore the experience of 16 self-identified LGBQ clients of subtle forms of discrimination, which they referred to as 'microaggressions'. PA illuminated common themes of microaggressions experienced by the participants in therapy.

Similar to Israel et al. (2008), Shelton and Delgado-Romero (2011) found that unhelpful experiences may occur even when the therapist appears to hold an inclusive attitude towards same-sex sexual orientation. Such unhelpful experiences involved a disproportionate expression of positivity towards matters around the sexual orientation of the client, in comparison with the other matters that were affirmed during therapy.

When talking about discrimination experiences in therapy, Shelton and Delgado-Romero's (2011) participants described how therapists assumed that sexual orientation is the cause of all presenting issues or avoided/minimised its impact on their presenting issues. Participants also described how therapists attempted to over-identify with their difficulties linked to their sexual orientation, making stereotypical assumptions, expressing heteronormative bias (e.g., asking gay men if they had girlfriends), or warning them about the 'dangers' of identifying as a sexual minority. As a result of these experiences, participants expressed feeling uncomfortable, powerless, invisible, rejected, confused, misunderstood, manipulated or even forced to comply with therapy. Participants felt frustrated, angry and invalidated. Some participants reported that fear of being seen as abnormal or different stopped them from exploring their sexual orientation.

As with studies mentioned above, a more homogenous sample could have revealed different themes. Additionally, the interviews took place in focus groups and participants could have been prevented from reflecting deeper on their experience, or the topics discussed could have coloured how participants presented their experiences. Finally, Lilienfeld (2017) would challenge the use of 'microaggression' term by Shelton and Delgado-Romero (2011). According to Lilienfeld (2017), such a term is conceptually and methodologically underdeveloped in the field of psychological research on subtle forms of prejudice. Instead, Shelton and Delgado-Romero (2011) could have asked participants about their "unhelpful experiences in relation to their sexual orientation" and also refrained from using the term "microaggressions". Consistent with their phenomenological approach, this could encourage their participants to define and describe in their own terms their subjective experiences of prejudice in therapy. A study with a more homogenous sample, with face to face 1:1 interviews exploring in-depth the lived experience and meaning of not only 'microaggression', but all related unhelpful therapy experiences of sexual minority individuals, could provide even richer data and deeper insights.

Reading the abovementioned studies and thinking forward regarding further research to capture the affect, texture and essence of the unhelpful experiences of gay men in therapy, it could be meaningful to look at Goettsche's (2015) Interpretive Phenomenological Analysis (IPA) with seven LGB individuals in the USA, of which two were gay men. Participants here

expressed that historical experiences around sexual identity discrimination outside of therapy may, in some cases, influence expectations and concerns about therapeutic experiences. Goettsche's (2015) participants described, how, when ruptures occur in therapy, therapists' defensiveness may prevent the repair of these ruptures, whereas receptivity and validation of the experience of the client can be experienced as helpful.

Participants also reflected a tension between appreciating when therapists acknowledged the particularity of their experience as sexual minorities and when their experience was normalised. It seemed important that sexual minority status, whilst acknowledged, was not used to make assumptions about the client's experience. These accounts seem to reflect the core values of Counselling Psychology which emphasise the client's authority on their experience in order to foster a flourishing therapeutic relationship (Strawbridge & Woolfe, 2010). However, only two of the participants were gay men. Goettsche (2015) argued that the influence of gender on therapeutic experience could mean that more men in the sample would raise different concerns. Moreover, most participants were highly educated professional therapists. This can imply that the participants were more aware of processes in therapy. Consequently, their accounts might have been shaped by knowledge and terminologies specific to their education/profession that do not represent the experiences of clients who are not therapists.

## **2. 4. The present study**

### **2.4.1. *Rationale***

Qualitative methods have added rich insights and greater comprehensiveness to the existing research regarding the unhelpful experiences of SIGM in therapy. However, there is limited available qualitative research exploring the unhelpful experiences of SIGM in therapy. Moreover, most of this research has used methods that have provided an insight into these experiences on a descriptive level, lacking phenomenological depth. Furthermore, samples in these studies have lacked homogeneity, limiting the transferability of understandings around these experiences. Of these studies only one took place in the UK (Mair & Izzard, 2001). Meanwhile, several changes have taken place in Western society in terms of law and guidelines on how to work therapeutically with gay men. These changes might impact upon how SIGM experience unhelpful incidents in therapy now.

Considering the limitations of the studies discussed above, the present research aims to explore 'how do self-identified gay men in the UK experience unhelpful incidents in therapy'. As will be discussed in the next chapter, the method used is IPA, as it can be suitable to explore the phenomenon of interest in more depth (Smith, Flowers, & Larkin, 2009) than most existing qualitative research has, providing insights that have been missing from the

existing quantitative research. Davies and Aykroyd (2002) highlighted the importance of therapists endeavoring to be constantly aware of that which might hinder their psychological contact with sexual minority clients and their subjective experiences. Considering that SIGM clients might experience different things as helpful or unhelpful (Mair, 2003), the knowledge produced by the present research using IPA could enhance the empathic understanding of clinicians working with SIGM clients and help them attune better to what is helpful (Smith et al., 2009). Considering that much research rigorously supports the link between empathy and effective therapy (Elliott, Bohart Watson, & Greenberg, 2011), the present research could hopefully inform a more effective, ethical and therapeutic practice with SIGM clients.

Therapists are naturally influenced by their own experience and training. It is vital, however, that therapists endeavour to listen and strive towards understanding the meanings of the unique experience of their clients throughout the process of therapy (Bor, Chaudry, & Miller, 2017). As I identify as a gay man and I have been using therapy for a while, I am hoping that this research will also encourage me to let aside my personal perceptions of what may be unhelpful in therapy and to more empathically attune to my SIGM clients and the unique world they inhabit.

#### **2.4.2. *Relevance to Counselling Psychology***

Milton (2010) argued that Counselling Psychology, as a scientific and applied field, has a holistic interest in the human experience. It is concerned with what is helpful and what is unhelpful for individuals, not just in therapy, but also through research and movements that can tackle the effects of oppression in one's wider societal context. Milton's (2010) argument is reflected in the concern of the present research about societal discrimination and the researcher's interest in how this might be experienced in therapy. The aim of the present research is to explore the experiential impact of unhelpful incidents linked to one's sexual/affectional orientation in relation to themselves and others in and beyond the therapy room.

Furthermore, the present research echoes the British Psychological Society's (2012a) guidelines that encourage applied psychologists "to be knowledgeable of the diversity of sexual and gender minority identities" (p.7) beyond the common medical and academic literature that may pathologise or encourage unhelpful stereotypes for sexual minority clients. Langdridge (2014) urges that therapists have the responsibility to educate themselves about the culture of an identifiable minority group in order to become suitably sensitive to their needs and be able to undertake therapeutic work with them. The aim of the present study reflects Parritt's (2016) argument that Counselling Psychology can help the

majority learn from the 'other', in order to promote diversity and advocate for an inclusive therapeutic practice and wider society.

By employing IPA and focusing on the subjective experiences of the participants, this study echoes Strawbridge's (1994) emphasis on empathy and on "a practice led model based on: co-operative inquiry; the valuing of feelings; a respect for the reality of differing universes of experience and meaning; and, the preserving, fostering and releasing of potential" (p. 5-12). Accordingly, the present research may encourage Counselling Psychologists and other practitioners to enhance their empathic practice when working with SIGM clients. Such an empathic practice will be underpinned by the unique principles of Counselling Psychology that emphasise the importance of a therapeutic relationship that values the subjective experience of the client in order to help them reach their full potential (Strawbridge & Woolfe, 2010).

### **3. Chapter Two: Methodology**

#### **3.1. Research aim**

As discussed above, there seems to be little available research on how SIGM experience unhelpful incidents in therapy. As far as the researcher is aware, no other study has taken place in the UK since Mair and Izzard's (2001) research. Hence, more studies are needed in order to look at these experiences in depth and to enhance the transferability of our current insights regarding this topic. The aim of this research is to explore how SIGM in the UK experience unhelpful incidents in therapy, where these incidents are perceived to be linked to their sexual/affectional orientation.

##### **3.1.1. *Research question:***

How do SIGM in the UK experience unhelpful incidents in therapy?

##### **3.1.2. *Specific research aims:***

1. To gain an insight into the experience of unhelpful incidents in therapy that were perceived to be related to the sexual minority status of SIGM.
2. To gain a deep insight into the meaning SIGM assigned to these experiences.
3. To understand how these unhelpful experiences might have impacted the therapeutic processes of SIGM.

#### **3.2. Rationale for selecting a qualitative research paradigm**

The quantitative and qualitative research paradigms embrace different assumptions about the nature of knowledge and human experience (Bhati, Hoyt & Huffman, 2014). Based on these assumptions, quantitative methods commonly aim to quantify the data and control the empirical variables, searching for causal or correlational relationships between them (Pontoretto, 2005). The quantitative paradigm is often driven by a positivistic inquiry and relies on hypothetico–deductive methods (McGrath & Johnson, 2003). On the other hand, the qualitative paradigm incorporates the words of participants to describe complex psychological events and experiences (Pontoretto, 2005). However, Brannen (2005) argued that both qualitative and quantitative paradigms can be concerned with meanings in an inductive manner. Still, quantitative paradigms aim to use large samples in order to confirm a hypothesis, embracing a nomothetic and etic perspective (generalizable and universal) over an idiographic and emic perspective (individual and particular) that is typically adopted in qualitative paradigms (Pontoretto, 2005).

Considering the above, a quantitative research paradigm would not allow for the voices of my participants to be expressed as openly as a qualitative research paradigm. Barker and Langdridge (2009) urged researchers to be aware when silencing the experiences of 'silenced sexualities'. Consequently, a qualitative paradigm seemed more suitable for meeting the aims of my research to gain deeper insight about the phenomenon of interest. Qualitative methods are recommended for researching the experiences of marginalised people (Kral, Burkhardt, & Kidd, 2002) and illuminating their perspectives (Morrow, 2007). A qualitative paradigm could well complement recent research findings on the unhelpful experiences of SIGM in therapy that have been predominantly quantitative, providing the depth and detail that has been missing (Brannen, 2005).

My *axiology* has also influenced the research paradigm I selected (see Creswell, Hanson, Clark & Morales, 2007). The same values that enthused me to follow the path of Counselling Psychology seem to coincide with my choice of a qualitative paradigm; the interest in the subjective experience and the embodiment of the core clinical skills of empathy and congruence (McLeod, 2003). Also, given that the research topic is somewhat close to my personal experience, it seemed appropriate that I select a paradigm which transparently acknowledges and accounts for my impact on the study as a researcher through constant reflexivity.

### **3.3. Rationale for Interpretative Phenomenological Analysis (IPA)**

Grounded theory (GT), discursive methodological approaches (DAs) and different phenomenological approaches were considered before IPA was selected as the most suitable qualitative method to reach the aims of the research question. This section illustrates the rationale for selecting IPA.

GT seemed appealing because of its inductivist approach to inquiry (Charmaz, 2008). GT could allow the generation of knowledge and offer general theoretical claims about the social processes that underlie the unhelpful experiences of SIGM in therapy (Willig, 2013). Though relevant to the rather dynamic phenomenon of discrimination in therapy, this knowledge was considered to avert from the focus of the present research. The present research aims to fill the gap of the existing literature by offering insights about the lived experiences of unhelpful incidents in therapy linked to one's sexual/affectional orientation. Whereas GT is more concerned with the contextual causes or consequences of a phenomenon, IPA focuses on the psychological texture and individual meaning of an experience (Willig, 2013). IPA was therefore deemed as a more appropriate methodology for capturing the quality and texture of the subjective experiences of SIGM who had unhelpful incidents in therapy.

DAs, such as Discursive Psychology and Foucauldian Discourse Analysis, were also considered. Similar to IPA, DAs place emphasis on the use of discourse as a means to understand the ways individuals experience and make sense of specific phenomena (Eatough & Smith, 2008). For example, Discourse Analysis (Potter & Wetherell, 1987) could help examine the way SIGM use language in order to describe their unhelpful experiences in therapy, also allowing for the consideration of the power differential between therapists and clients who are SIGM. Nonetheless, unlike IPA, DAs with their strong commitment to social constructionism would divert from the focus of the present research and potentially miss the idiographic, subjective lived experiences and sense-making of the participants (Starks & Trinidad, 2007).

Phenomenological methods felt more relevant to this study because of their interest in the exploration of human experience (Langdridge, 2007). Descriptive Phenomenology (DP) (Giorgi, 1997; Giorgi & Giorgi, 2003) with its widely used systematic Husserlian method focuses on lived experiences and was considered suitable for this study. However, DP uses maximum variation sampling and focuses on the descriptive level of an experience (Langdridge, 2007). I felt that a homogenous sample and a more interpretative approach could be more suitable for illuminating the idiographic experiences of SIGM in more depth.

The Hermeneutic approach (Van Manen, 1997) also seemed appealing with its interpretative focus and acknowledgement of the role of the researcher in the co-construction of meaning. Nonetheless, Van Manen's approach highlights a search for the universal within the particular rather than emphasising the individual account. It also avoids a prescriptive approach to analysis, claiming that this could prematurely foreclose potential insights (Langdridge, 2007). It encourages researchers' flexibility and deep involvement in the analysis. Considering my commitment to reflexivity and my relationship with the research topic, I felt that the lack of prescriptions about how to analyse the data with the emphasis on involving oneself in the data, could lead to the over-interpretation or enforcement of my views onto the data. This could jeopardise the accounts of my participants. In contrast, given my relative inexperience in qualitative research, IPA's structured approach to analysis elucidated in several papers (e.g. Smith & Osborn, 2008) seemed alluring.

IPA with its idiographic approach emphasises the particular over the universal and highlights the diversity and variability of participants' experiences. The researcher can endeavour to access an 'insider's perspective' (Conrad, 1987) into the inner world of the participants, whilst accounting for the researcher's and participant's intersubjectivity in the process of meaning making (Smith & Eatough, 2006). As such, I felt IPA to accurately echo my axiology, epistemology and research aims. The idiographic focus may presumably limit the



ability to generalise findings, but Warnock (1987) argues that exploring the particular in detail could also lead us to the universal. Thus, IPA seemed suitable in pursuing insights into a span of individual lived-experiences of unhelpful incidents in therapy (Langdridge, 2007). Moreover, IPA was developed by a psychologist (Smith, 1996) for psychological research and has also been advocated as particularly suitable for researching sexuality (Smith, Flowers, & Larkin, 2009), something that was taken into consideration when selecting it as a suitable methodology.

Finally, my epistemological position and my adherence to the values and ethos of Counselling Psychology has influenced my interest in IPA. IPA focuses on giving voice to the subjective experiences of participants in order to understand their experiences and how they make meaning of them. As will be discussed below, IPA acknowledges that the interaction between the researcher and the participant may influence the findings of the analysis (Smith et al., 2009). This parallels my epistemological position underpinned by the notion that there are multiple valid realities, and that these realities are in fact meanings also influenced by interpersonal contexts (Slife & Christensen, 2013). It also echoes the Professional Practice Guidelines for Counselling Psychologists in the UK (BPS, 2005). These guidelines encourage Counselling Psychologists to “engage with subjectivity and intersubjectivity” and “to know empathically and to respect first person accounts as valid in their own terms; to elucidate, interpret and negotiate between perceptions and world views” (p.1-2). Consistently, IPA argues that interpretations should be formed through attending to the accounts of the participants and refraining from the influence of any external sources, regardless of how relevant these may seem (Eatough & Smith, 2008).

### **3.4. IPA overview and philosophy**

IPA has a commitment to the deep examination of lived subjective experience and the meaning an individual gives to that experience (Eatough & Smith, 2008). It is often used in research to unfold the existential impact an experience has had on the participants (Smith, 2011). IPA is underpinned by three different positions: the phenomenological, the hermeneutic and the idiographic. These positions are discussed below:

#### **3.4.1. *Phenomenological position***

Phenomenology is concerned with how humans experience and understand the world via consciousness, awareness and perception (Gee, 2011). Phenomenology attempts to capture one’s lived ‘lifeworld’ (*‘lebenswelt’*; Husserl, 1970), one’s “world as concretely lived” (Langdridge, 2007, p.23). IPA endeavours to understand and get as close as possible to the individual’s lived experience and the sense-making of it; ‘what it is like’ to be in their life-world in relation to a specific phenomenon (Eatough & Smith, 2008).

IPA discards the Cartesian dualism of person/world, subject/object, mind/body. It adopts Heidegger's proposition that humans are 'being in the world' and attempts to reach the uniquely embodied intersubjective experience of a person. (Eatough & Smith, 2008). IPA incorporates Merleau-Ponty's (1962) concept of our experience in the world being embodied, that our body connects us with the world and provides us with a vehicle to be in the world and understand it. As such, one's perception of others is filtered through and limited to their own unique and embodied perspective (Finlay, 2011).

Husserl advocated that only by bracketing ('*epoché*') our 'natural attitude' (i.e., daily preconceptions and assumptions) one can be open to understand 'what it is like' through the eyes of another and how a phenomenon manifests itself in another individual's consciousness (Finlay, 2008). Only then one can adopt a 'phenomenological attitude' (Gee, 2011). Consequently, the researcher can try to see the object in a new light and perceive 'the things themselves' in order to demarcate and describe the 'essences of a phenomenon' as they manifest in participants' consciousness ('*eidetic reduction*'; Smith et al., 2009).

### **3.4.2. Hermeneutic position**

The hermeneutic position is concerned with how humans understand and interpret their world (Gee, 2011). IPA aims to study participants' experience from their own perspective and appreciates that the insight obtained from the analysis consists of an *interpretation* of the world the participants inhabit (Larkin, Watts & Clifton, 2006). Accordingly, the world the participants inhabit is not fully and directly accessed (Smith et al., 2009). Rather, the researcher engages in interpretations and attempts to make sense of the participant's sense-making. This is what Smith and Osborn named a '*double hermeneutic*' (Langdridge, 2007).

IPA's conceptualisation of interpretation has some influences from Sartre's writings (1956/1943). Smith et al. (2009) understood Sartre's philosophy to suggest that people's experience of their world is shaped by the relative presence or absence of others; one's conscious experience "becomes apparent on being aware of being the object of the gaze of the other" (p.20). Thus, we can make sense of the emerging affective experience when we consider the interpersonal context of this experience (Smith et al., 2009).

IPA particularly echoes Heidegger's (1962/1927) ideas that emphasise the context, consciousness and interpretation which colour people's meaning-making processes. Heidegger coined the concept of '*Dasein*' (being-there), meaning that people's experience of being is intertwined with their context (Smith, et al., 2009). This leads to the important role of intersubjectivity and how my 'fore-conceptions' as a researcher can be vital touchstones in helping me to understand participants' experiences, as bracketing can only be partially

achieved (Smith et al., 2009). Moreover, the '*hermeneutic circle*' in IPA advocates that, in order to understand an individual's experience as a whole, one must look at its parts and in order to understand its parts, one must look at the whole (Smith et al., 2009).

According to IPA it is not possible for the researcher to directly access the participant's experience when interpreting and making sense of their accounts. Still, IPA shares the idea that, through the detailed analysis of the participant's account, the researcher can achieve "an understanding of the utterer better than he understands himself" (Schleiermacher, 1998, p.266). This does not mean that using IPA one could exceed the participant's understanding of their experience. Rather, IPA could allow for a new insight to emerge about this experience (Smith et al., 2009). This insight would remain only an interpretation of and not a window onto the participant's subjectivity (Packer, 2011). Still, the interpretation is formed from close attention to the accounts of the participants and not from external sources (Eatough & Smith, 2008).

### **3.4.3. Idiographic position**

IPA with its idiographic commitment focuses on how particular individuals have experienced particular phenomena in a particular context, focusing on the particular rather than the universal (Eatough & Smith, 2008). This position can be understood as contrasting the *nomothetic* perspective that is commonly used in mainstream psychology research to verify causal laws (Pontoretto, 2005). This is why IPA studies use small, purposefully selected samples, aiming for in-depth, rich analyses of individual perspectives (Smith et al., 2009).

IPA achieves its commitment to idiography by striving for in-depth, rich analysis of individual perspectives (Smith et al., 2009). This involves the thorough analysis of a single case study (Bramley & Eatough, 2005) or the thorough analysis of one case before moving on to the next case. Then, the researcher can proceed to a cross-case analysis, where the individual accounts are interrogated for convergence and divergence (Smith, 2004). Subsequently, the findings can be understood in relation to existing theory (Smith et al., 2009) and the individual accounts may help us understand the universal (Evans, 1993).

With its idiographic position, IPA aims to say something meaningful about the phenomenon of interest (Smith et al., 2009). The IPA researcher might suggest some general claims about the topic of interest, but will do so cautiously considering the uniquely embodied and contextual particularity of an individual experience (Smith et al., 2009).

### **3.5. Research Paradigm and Philosophy**

Below I clarify the research paradigm and the ontological and epistemological position that underpin this study. Subsequently I illustrate how these concepts link with the use of IPA.

### 3.5.1. Research Paradigm

This study, with its qualitative paradigm aims to produce *phenomenological knowledge*; knowledge about the quality and texture of the subjective experience of SIGM in an attempt to understand their unhelpful experience in therapy. With its *interpretative phenomenology* stance, however, the present study goes beyond the *experiential*, “face value” level and endeavours to see the phenomenon of interest within wider sociocultural and psychological meanings (Willig, 2012) and theoretical contexts (Larkin et al., 2006). In doing so, I assume that there is more than one *world* to be explored. (Willig, 2012). This is consistent with the *constructivism-interpretivist paradigm* that adheres to the notion of multiple and valid realities and adopts a hermeneutical approach to bring hidden meanings to the surface through deep reflection (Ponterotto, 2005).

Nonetheless, the present research has some influence from the *critical-ideological paradigm*. My anti-discriminatory values had a great impact on the topic, purpose and methods I used (Ponterotto, 2005). Similar to the present research, pioneering critical theorists, such as Max Horkheimer, Herbert Marcuse and Theodor Adorno, shared the idea that “injustice and subjugation shape the lived world” (Kincheloe & McLaren, 2000, p. 280). Similar to constructivists, criticalists believe that a social-historical context can shape reality. However, they additionally emphasise that this reality is affected by power relations. As such, criticalist researchers aim to help emancipate oppressed groups through their studies (Ponterotto, 2005). However, the present study *hopes*, but does not *aim*, to empower SIGM. An Action Research methodology would have been more suitable for such an aim (see Tolman & Brydon-Miller, 2001).

### 3.5.2. Ontology

Ontology is concerned with what can be known about reality. What I hold to be true inevitably colours the assumptions I make through the research process and how I approach them (Willig, 2013). I understand my ontological position to be closely aligned with what literature refers to as ‘*Hermeneutic Realism*’.

Slife and Christensen’s (2013) term “hermeneutic” implies that psychology’s subject matter, such as our feelings, thoughts, and behaviours, consists more of contextually created meanings than self-contained objects. The ontological “realism” suggests the existence of an objective reality. Hermeneutic Realism, however, understands reality to be more constituted by meanings than objects, and that these meanings are potentially equally “real” as any object or objectivity (Slife & Christensen, 2013). Slife (1993) assumes that context is vital for these meanings. In the present research, for example, the same therapist’s behaviour could mean contrasting things according to the client’s past and future experiences in the duration

of his therapy. Therefore, unlike objects, meanings are liable to change because of their sensitivity to context. By moving towards such a meaning-oriented approach of understanding the human experience, Hermeneutic Realism recognises the intersubjective nature between the observer (researcher) and the observed (participant) (Slife & Christensen, 2013). It also recognises what Jung (1964) noted as “possibility” and “otherness”. In the present research, for example, the experiences of SIGM participants encompass not just the unhelpful events and processes that took place, but also the “possible” and “other” helpful ones that did not take place.

Similar to the aforementioned principles of IPA and Counselling Psychology, this meaning-oriented approach of seeing the world emphasises the relational over the individual. With Hermeneutic Realism, Slife (2004) moves on to the concept of a relational ontology. Slife and Christensen (2013) described the relational force as highly influential in shaping an experience, as memories are also shaped in relation to contextual and relational variables. Moreover, whereas mainstream psychology sees biases as negative influences in the process of research, Hermeneutic Realism sees them as inevitable and directing the researcher’s psychological topics of interest. Thus, I as a researcher have historical/cultural biases that cannot be avoided but can actually help in guiding further exploration (Slife & Christensen, 2013). Consistently, Willig (2012) urges qualitative researchers to be aware of how their own values, assumptions and experience may impact their meaning and interpretation of the qualitative data.

Similar to Critical Realism, Hermeneutic Realism does not adhere to beliefs held by Naive Realism, nor to the notion that all knowledge/reality is nothing but human construction. Parallel with ideas proposed by Heidegger and Merleau-Ponty, Hermeneutic Realism sees human existence as “fundamentally unitary and situated in-the-world; humans are engaged, fully embodied agents, inevitably enmeshed in meaningful contexts of historical-cultural practices” (Yanchar, 2015, p. 109).

### **3.5.3. Epistemology**

Epistemology is concerned with ‘What can we know?’ (Willig, 2013). Willig (2013) explains that epistemological positions in qualitative research are on a spectrum with *Naïve Realist* on one end (that research data can reach accurate representations about an objective reality), to *Radical Relativist* on the other end (the reality reached is relative to our historical/social/cultural/linguistic construction of it; the concept of ‘truth’ is rejected). In between these polar opposite ends there is the *Critical Realist* position which embraces the existence of one reality/knowledge that can only be partially reached because of contextual influences (Willig, 2013).

My research paradigm and ontological stance embrace the existence of multiple, constructed realities that are influenced by situational contexts. Therefore, I consider myself somewhere between the Relativist and Critical Realist epistemological position. I share Heidegger's view of someone (participant) being continually a 'person in context' and of myself (researcher) attempting to understand their lived experience and meaning-making as contextual beings (Langdrige, 2007).

Merging my ontological and epistemological views means that as a researcher I believe that I can only reach a part of my participants' several realities (Willig, 2013), and that these realities are more meanings than objects (Slife and Christensen, 2013). Accordingly, I see the concept of unhelpful experiences of SIGM in therapy as real. There are several ways these real experiences might manifest themselves. They are composed of the participant's different meanings that are influenced by different given contextual and relational processes. I can only capture part of my participant's experiences. My own reality, meanings, context, and intersubjectivity with the participant influence the findings presented in the next chapter. Therefore, any psychological knowledge generated is a co-creation between myself as a researcher and the participants (Willig, 2013).

#### **3.5.4. IPA's link with Research Paradigm and Philosophy**

IPA's philosophical underpinnings seem compatible with what my ontological and epistemological positions hold: the existence of many realities coloured by the background/context of each individual, the emphasis on the lived experience and the meaning attached, the belief that the researcher may not fully understand but can come closer to understanding one's subjective experience and the concept of inter-subjectivity (Smith et al., 2009). Methodological choices in this research are therefore informed by and intertwined with my selected research paradigm and philosophical lens.

#### **3.6. Reflexivity**

*"But the qualitative researcher [...] is simultaneously involved*

*in auto/biographical work of their own" (Coffey, 2002, p. 314)*

In line with this quote, Langdrige (2007) clarified that reflexivity involves the conscious and reflective process of the researcher, where one acknowledges how their questions, methods and own subject position might impact the psychological knowledge generated in research. Throughout the research process, I engaged in personal (how my axiology may impact the research) and methodological (how chosen methodological procedures may impact results) reflexivity (Finlay, 2003).

My research interest in the experiences of discrimination in therapy emerged from my own background as a gay man. I was born and raised in a strictly Christian Orthodox culture with a father who was a priest. Consequently, I was constantly exposed to subtle and overt homophobic and heteronormative messages even from individuals who were providing me with care and parental love. These messages were implying that same-sex romantic and sexual feelings are not of the same value as the same feelings towards the opposite sex. In fact they were undervalued and diminished to urges of deviation that needed to be denied. I soon became aware how this deeply invalidating view of my own existence was harmful to me, even more so because it was coming from people who also showed deep love and care for me. This is because it would make it harder for me to identify and manage the negative impact of the discriminatory messages on my well-being and psychological growth.

The role of the therapist is often described as paralleling that of a parent, and offering *unconditional positive regard* (Rogers, 1957), *limited reparenting* (Rafaeli, Bernstein & Young, 2010), or an *emotional corrective experience* through the *transference* of experiencing the therapist as a parent (Cooper, 2007). As such, I considered the ethical and therapeutic importance of sexual minorities being exposed to an affirmative and inclusive, as opposed to discriminatory or heteronormative, therapeutic contact with their therapist. I thought that research on the unhelpful experiences of gay men in therapy would help other therapists, as well as myself, to best attune to what might feel helpful or affirmative to individual SIGM clients.

Upon conducting this research I needed to be aware of how my own lifeworld was interfering with the accounts of my participants. My abovementioned background meant that I risked dismissing the negative impact of the discriminatory incidents on my participants. I considered that silencing their experiences in research would be as unethical and possibly damaging as silencing them in everyday life and therapy. This was particularly relevant when conducting the interview and analysis process. Equally, the accounts of my participants brought to surface personal experiences of discrimination and difficult emotions. It was therefore important to remain reflexive about that throughout the research process and work through these personal experiences in therapy. This would help me better preserve and illustrate the authenticity of the unique experiences of my participants in this study.

I also have a professional interest in my research topic. In line with the scientist-practitioner model I aspire to continuously inform my practice and participate in research, particularly around exploring the experience of clients in therapy (Strawbridge & Woolfe, 2010). I was hoping that my engagement with this research would encourage me to put aside my

personal perceptions of what may be unhelpful in therapy and to more empathically attune to my SIGM clients and the unique world they inhabit.

Considering Heidegger's and Merleau-Ponty's notion of the bracketing process as rather imperfect (Langdridge, 2007), I endeavoured to remain reflexively aware throughout the research process, but also mindful to not become preoccupied with introspection at the expense of the voices of my participants (Finlay, 2011). Meanwhile, I hoped that also being a gay man could enhance my '*hermeneutic reflection*', that is, my empathic and interpretative understanding of the lifeworld of my SIGM participants (Shaw, 2010).

### **3.7. Methodological Design and Procedures**

#### **3.7.1. Sampling**

IPA, as a suitable method to explore the specific phenomenon of interest in depth, does not require a definitive sample size (Smith & Osborn, 2008). IPA's idiographic commitment to understand the phenomenon of interest in particular contexts (Smith et al., 2009) implies the suitability of smaller sample sizes. A relatively homogenous sample of six participants was selected purposively (Willig, 2013). A sample size of six appeared sufficient to balance the task of exploring individual accounts in depth and obtaining enough accounts to cross-examine within the time framework of my doctoral training course (Langdridge, 2007).

#### **3.7.2. Inclusion and Exclusion Criteria**

In IPA, a homogenous sample can ensure that the focus of exploration is only on one phenomenon (Smith & Osborn, 2007) so that analysis can reach meaningful depths (Smith et al., 2009). Considering my research aims and ethical recommendations (BPS, 2014), the following *Inclusion and Exclusion Criteria* were set in order to ensure sample homogeneity and meaningful findings:

##### **3.7.2.1. Inclusion Criteria**

1. *Self-identify as a gay man and be above 18 years of age.*

I considered enquiring about participants' self-identification, as this has been assumed to be a suitable method for assessing participants in research (Worthington & Reynolds, 2009). It has also been recognised that sexual orientation and gender identity are two distinct (often overlapping) constructs (American Psychological Association, 2008; Moradi et al., 2009), i.e., an individual can be a trans man and identify as heterosexual/gay/bisexual/asexual. Therefore, I decided to take accounts from individuals who identify as gay but also as men.



It was decided that the inclusion criteria would require participants to be above 18 years of age because of my lack of experience in the specific ethical procedures that are required in order to be able to recruit individuals under the age of 18.

*2. Have had an unhelpful experience in talking therapy that was perceived to be related to their sexual identity.*

This clarification could allow the focus of exploration to remain only on the phenomenon of interest so that the analysis can illuminate meaningful themes (Smith et al., 2009).

*3. Have sought therapy after UKCP and BPS updated their guidelines of how to work with sexual minorities (thus after 2014) and have completed their therapy at least six months prior to the interview.*

Recently, the BPS (British Psychological Society, 2012a; 2012b) updated the guidelines for therapists working with gay clients and the Consensus Statement (UKCP, 2014) banned 'Conversion Therapies'. Therefore, I considered that unhelpful incidents in therapy that have taken place prior to these updates would have been of different content than the ones following the implementation of the new guidelines.

However, it has been difficult to identify enough participants with this criterion. As the focus of the research is the current experience of unhelpful incidents and not the content of incidents that occurred in therapy, I included participants who had an unhelpful experience in therapy even before 2014, as long as they presented themselves as able to recall their experiences in a meaningful way. Moreover, one participant had his unhelpful experience in therapy three months prior to his availability for an interview. Consequently, the minimum of six months for participants to have some time to make sense of their experience was minimised to three months.

### 3.7.2.2. Exclusion Criteria

*1. Individuals with a severe and enduring mental health diagnosis which might have an impact on their memory/cognitive functioning were excluded from the sample.* This is so participants could reflect on the memory of the unhelpful incident as accurately as possible. It was also a way to manage the risk that participants with mental health diagnoses, such as depression, being further harmed emotionally/distressed.

*2. I decided to exclude individuals with active suicidality and self-harming presentations.* This exclusion was to manage the risk of possibly inducing further emotional harm and distress to participants. This criterion was clarified to participants prior to giving their consent

to participate in this study. None of the participants who showed interest reported suicidal or self-harming thoughts or behaviours.

3. *Substance abuse and alcohol can affect an individual's memory and perception of an experience, and individuals who were actively abusing drugs or alcohol were thus not included.*

4. *Individuals taking medication affecting their cognitive abilities were also excluded.* This was so participants could give an accurate as possible account of their lived experience and to manage the risk of further cause of distress.

### **3.7.3. Recruitment**

Participants were recruited through flyers (Appendix A) and snowballing (Goodman, 1961). Various establishments that were considered as appropriate (e.g., LGBTQI+ Support Charities) were contacted to ask for permission to leave/post some flyers at their premises. Following the BPS (2013) ethics guidelines for internet-mediated research, LGBTQI+ Charities, Pink Therapy and LGBT societies of the University of London were approached and asked whether they could post the flyer on their social media webpages.

Individuals who indicated interest by contacting the researcher were sent the 'Participant Information Sheet' (Appendix B) Potential participants were encouraged to allow themselves a minimum time of 24 hours to consider whether they wanted to participate. Following a 'Screening-Phone Call' (Appendix C), I discussed and arranged interview dates, times and venue with the selected participants.

All communication encompassing the above steps took place through my University E-mail account.

### **3.7.4. Safeguarding considerations**

The Inclusion and Exclusion Criteria and the 'Screening-Phone Call' aimed to evaluate participants' suitability for the study. This was an essential safeguard juncture, as researcher "must always evaluate the extent to which simply *talking about* sensitive issues might constitute 'harm' for any particular participant group" (Smith et al., 2009, p.53).

Moreover, all interviews took place within the premises of City, University of London. It was possible for students to book private rooms in the University for research purposes. The University could provide security in case anything out of the ordinary occurs.

### 3.7.5. Data Collection

#### 3.7.5.1. Background of participants

Participants completed a background questionnaire (Appendix D) prior to their interview. This was to elicit some information about their history that could contribute meaningfully in understanding their perspectives later on. Based on this questionnaire and information shared during the interviews, the following table of their pseudonym profiles was formed:

<b>The profile of the participants (at the time of the interview):</b>	
<b>Brian:</b>	Brian is a 52 years old gay man who works as a therapist. He had several therapy experiences. The therapy he refers to took place in 2012. Brian did not specify the theoretical orientation of the therapist. Brian attended eight sessions. The therapy occurred during a time when Brian had some anxiety difficulties around his research studies. That is also the time when Brian moved back to his childhood home in the North of England. Brian describes his family environment and hometown to not have been supportive in terms of his gay identity and that is the reason he decided to move from there as an adult. The unhelpful incident he refers to involved his therapist disclosing his heterosexual orientation with no therapeutic benefit for Brian. Brian engaged in longer-term therapy with another therapist a year after he completed this therapy.
<b>Chris:</b>	Chris is a 57 years old gay man who is working as a therapist. Prior to that he used to be involved in biochemical research and work in hospital. He described these job roles to have made him more sensitive in appreciating human suffering and embracing diversity. He tried different therapies in the past. The therapy he refers to took place in 2016 and it was person-centred. Chris decided to engage in this therapy following several difficulties with his ex-partner, including their divorce. Chris described perceiving his therapist as overall "judgmental", "not relational" and "not understanding" when it came to Chris's sexuality. Chris attended 6 sessions and the ending of the therapy was unplanned. Chris did not attend any therapy following this experience, though he had three more courses of therapy in the past of different durations and with different therapists and modalities.
<b>James:</b>	James is 26 a years old gay man from West Europe. He did not complete university and chose to work instead to earn money. James described experiencing financial and family difficulties prior to starting therapy. His family difficulties were not related to his gay identity. James described his therapy as helpful in dealing with other than sexuality matters. The unhelpful incident he referred to mainly involved his therapist understanding being gay as the result of traumatic experiences. James did not specify the theoretical model of his therapy. His therapy took place in 2010. It lasted for 8 months and he did not have any other experience of therapy before or after the therapy he talks about in the interview.
<b>Manuel:</b>	Manuel is a 28 years old gay man. His parents are from South America. He is currently completing his postgraduate studies. The therapy experience he describes took place when he was seventeen years old (2005), the time he started discovering and acknowledging his sexuality. The unhelpful incident he referred to involve his therapist assuming that she knows what Manuel's experience of his gay identity was and often trivializing the discrimination he was encountering. Manuel did not specify what theoretical model his therapy was but it lasted for one year. Though he described finding it difficult to trust professionals following this experience, he later had three courses of therapy with different therapists for different reasons.
<b>Omar:</b>	Omar is a 27 years old man. Omar was born and raised in Asia. He moved to the United Kingdom when he was 23 and he has recently completed his master's degree in sciences. The therapy he is referring to was Cognitive Behavioural Therapy of twelve sessions and it took place in 2016. Prior to starting therapy, Omar broke up with his then boyfriend. Omar believes his therapist was also gay as he requested that from the service he had therapy. When talking about the unhelpful incident in therapy, Omar described his therapist not giving Omar space to explore what being gay means for him, but rather the therapist talking about his own opinions instead. Omar did not have any more therapy prior or after the therapy he is referring to in the interview.
<b>Thomas:</b>	Thomas is a 35 year old gay man from West Europe. Thomas is a therapist. The therapy he referred to in the interview took place between 2012-2016. It was a psychodynamic therapy. Thomas wanted to use therapy to talk about the ending of his long-term relationship and explore particular sexual behaviours he felt unsure about then. His therapist was also a gay man. However, Thomas described his therapist as being much older than him and having traditional views about the structure of romantic relationships. The unhelpful incident Thomas described involved perceiving a judgmental approach from his therapist who did not seem to accept him as a gay man who does not conform to traditional relationship views. Thomas reported finding it difficult to leave therapy though he was feeling angry with the therapist. Thomas had one year of therapy in the past with a female heterosexual therapist. He was hoping to feel freer to talk about his sexuality with a gay man therapist. He did not engage in any further therapy following the therapy he refers to in the interview.

**Table 1: The Profile of the Participants**

#### 3.7.5.2. Interviews

IPA invites participants to provide a first-person account of their experiences in depth (Smith et al., 2009). Suitable methods need to be considered to encourage participants to reflect

freely on their stories, thoughts and feelings about the phenomenon of interest. Several methods can be used in IPA studies for data collection (Smith et al., 2009). I felt that a semi-structured interview would be the most suitable way to explore the research question whilst simultaneously honouring the participant's experience (Langdridge, 2007). The idiographic element of IPA underlies the use of individual semi-structured interviews to collect first-person accounts of conscious, subjective, lived experiences (Smith et al., 2009).

Data was therefore collected via 1:1 semi-structured interviews. The framework of semi-structured interviews allows researchers to collect coherent descriptions of people's experiences; the researcher has sufficient flexibility to follow participants in the unpredictable depths and directions of their unique experiences (Smith et al., 2009). All audio-recorded interviews lasted approximately 60 minutes. The interviews had the form of a conversational style aiming to build a safe rapport which allowed participants to explore their experiences.

Rapley (2001) argued that it is common amongst IPA researchers to appreciate that interviews are not 'neutral' accounts of the experiences of the participants. Rather, they are co-constructed accounts. I believe the concept of co-construction of accounts to be epistemologically consistent with a semi-structured interview format.

#### 3.7.5.3. Interview Schedule

In IPA, the role of the researcher is to listen attentively and engage deeply with the 'lifeworld' of the participants in order to be able to produce a rich analysis (Smith et al., 2009). One could understandably argue that an interview schedule could counteract the aim of the interview in IPA, which is to enter the participant's lifeworld.

However, Giorgi (2010) argued that a fundamental rule of science goes beyond the documentation of a research study's steps, highlighting that the research has to also be able to be replicated. After all, within the research process both the interviewer and the interviewee are active participants. Thus, the use of an interview schedule could indicate to the reader how I might have influenced the findings. This could allow other researchers in the future to replicate this research process.

I constructed an Interview Schedule (Appendix E) to ensure consistency across the interviews and to design questions that aim to invite the participant to provide an account of their experiences in depth. This helped me plan in advance how to best introduce potentially distressing topics and to consider potential referral agencies for further therapeutic support if required by the participant (Smith et al., 2009).

Consistent with the recommendations of Smith et al. (2009), eight open interview questions (refraining from enquiring yes/no answers) were constructed, the first one inviting the

participant to recount the unhelpful incident on a fairly descriptive level and the following ones prompting for a more analytic or evaluative exploration.

Besides these eight questions, I endeavoured to follow each participant's train of thought and avoid leading questions in order to elicit subjective experiences free from potential distortions from my mediation. These questions were used to elicit more exploration on something the participant has already said in order to explore in depth the lived experience of participants around the phenomenon of investigation.

#### 3.7.5.4. Pilot Interview

Prior to interviewing participants, a pilot was used by interviewing two fellow trainee Counselling Psychologists to review the practicalities around the interview schedule, as well as to practice interview technique reflexivity. The ethical considerations when recruiting and interviewing the pilot participants were the same as for the actual participants.

The process of pilot interviewing helped me:

1. Feel more confident with the interview-process, including making the participant feel comfortable, discussing consent and debriefing, and keeping within the allocated time.
2. Be mindful of when I interrupt or misdirect the flow of my participant with questions based on my own presumptions and theories about the phenomenon of interest. I managed this by endeavouring to maintain a 'naïve listener' and 'curious' stance (Smith et al., 2009) and by embracing the core Rogerian conditions of empathy, congruence and unconditional positive regard (Rogers, 1957).
3. Be mindful of maintaining the focus of the interview upon the aims of the research.

#### 3.7.5.5. Recording and Transcription

IPA requires a verbatim record of data collection. Its primary aim is to interpret the meaning of the participant's account (Smith et al., 2009). I am mindful of Willig's (2013) criticism that IPA is overly reliant on the representational validity of language. Thus, upon recording and transcribing I included some prosodic features and nonverbal behaviours. This could add to a deeper understanding of the unhelpful experiences of SIGM in talking therapy (Smith & Dunworth, 2003; Finlay, 2006).

#### **3.7.6. Data Analysis**

Thus far, the literature on analysis in IPA has not established a particular 'method' to process the data. Rather, IPA has been described as an 'approach and sensibility' (Smith et

al., 2009, p.81) which is based upon the principles of phenomenology, idiography, hermeneutics and reflexivity and does not necessitate a specific set of procedural steps.

Smith et al. (2009) acknowledged the complexity in conducting an IPA analysis and offered a heuristic framework to process the data. As I am fairly new to IPA, it felt judicious to adopt this analytic framework. An outline of the analytic process is provided below:

#### 3.7.6.1 Step one – Reading and re-reading

The first stage of analysis involves in-depth focus on the participant. I strived to immerse myself in the original data by listening the audio-recording and reading and re-reading the transcript. Smith et al. (2009, p.82) advise being aware and avoiding “quick and dirty” processing of the data during this stage. I tried to be mindful about parts of the transcript where participants’ lived experience is recalled in more detail, as well as where contradictions and paradoxes are located. In doing so, I tried to bracket my own sense and observations about the transcript in order to actively engage with the data as it is (Smith et al., 2009).

#### 3.7.6.2 Step two – Initial noting

In the second stage, I continued to read and re-read the transcript whilst starting to take exploratory notes/comments on specific ways the participant appears to have experienced and makes sense of the unhelpful incident in therapy. A sample of how I analysed the transcript for each participant can be seen in Appendix F. Exploratory commenting was conducted in three ways:

- Descriptive comments (in black):

These comments were the content and the subject of what the participant has talked about (key words, phrases describing participant’s lifeworld).

- Linguistic comments (in green):

These comments focused on the participant’s particular manifestations of language (laughter, pauses, etc.).

- Conceptual comments (in red) and personal reactions (in blue):

These comments focused on my interrogative and conceptual insights that emerged from reading the transcript. This is when I started engaging in the ‘double hermeneutic’: I strived to make sense of how the participant understood the experience he was describing. Inevitably, the emerging interpretations were influenced by my experiential and professional understanding. Reflexive engagement was particularly useful during this stage (Smith et al, 2009). I was mindful of the advice of Smith et al. (2009) for the researcher’s interpretations

to remain grounded in the transcript. It was during this stage that the concept of 'hermeneutic circle' became relevant, as I started noticing the meaning of particular individual words and descriptions in the context of the wider interview account, and the essence of the wider account in specific individual words and descriptions.

#### 3.7.6.3. Step three – Developing emergent themes

I then engaged in the complex process of looking for emergent themes and reducing the volume of detail whilst preserving the density of the connections and patterns of the exploratory notes. This stage required that I had already mastered exploratory commenting of the original transcript comprehensively. This is because the analytic focus was now on the comments rather than the transcript itself. Through the 'hermeneutic circle', the original whole of the interview had become a set of parts and these parts were now joining together in another new whole. During this continuously developing and changing process, I named themes based on the essence of different and specific parts of the participant's account, only for each theme to later shape my understanding of the account as a whole.

#### 3.7.6.4. Step four – Searching for connections across emergent themes

After generating themes in the sequence as they emerged within the transcript, I tried to identify connections amongst these themes. My focus was on themes illuminating how my participants experienced unhelpful incidents in therapy in relation to their sexual/affectional orientation.

The patterns between themes were explored through 'abstraction' (grouping like themes under one super-ordinate theme), 'subsumption' (an emergent theme itself attains a super-ordinate status as it allows the clustering of other related themes) 'polarisation' (opposite relationships), 'contextualisation' (relationships with contextual and narrative elements), 'numeration' (looking for frequencies amongst themes) and 'function' (looking for functions of themes in the transcript, similar to discourse and narrative analysis but with an emphasis on the experiential aspect) (Smith et al., 2009). This process involved printing each theme on a piece of paper and then clustering them and placing them into envelopes based on their relationships to each other (Appendix G).

#### 3.7.6.5. Step five – Moving to the next case

I applied the above four stages thoroughly and systematically to analyse each transcript individually. The idiographic component of IPA implies that I had to bracket any ideas that emerged from previous analyses and treat each case on its own terms. It was my task then to ensure rigour by systematically checking the labels against the commentary and the relevant extracts of transcript.

#### 3.7.6.6. Step six – Looking for patterns across cases

Finally, I tried to identify patterns across the six cases. I explored how one identified theme was perhaps illuminating a different one, what some of the connections between the themes of each case were and which themes seem to be the strongest. As such, I generated a table of Master Themes and their Subthemes for the group of all six cases (see Analysis Chapter).

#### 3.7.6.7. Interpretation

The identified Master themes and corresponding Subthemes were analysed further with interpretations based on supportive quotes from the accounts of the participants (Smith et al., 2009). Consistent with Ricoeur's (1970) *demythologising* (empathic) and *demythifying* (suspicious) approaches for understanding meaning (Langdridge, 2007), two levels of interpretation in IPA can be the more descriptive, empathic interpretation that aims to enter the world of the participant, and the interpretation that critically interrogates the account of the participant and aims for further insight into its origin, nature and meaning (Eatough & Smith, 2008). The latter interpretation should be more tentative; deeper levels of interpretation may enhance the research by evoking deeper insights, but they might also imply ethical issues of imposing a meaning and disregarding the voice of the participant (Larkin, et. al, 2006). Larkin et al. (2006) clarify that by drawing on existing theoretical constructs and formulations IPA can go beyond the stage of master themes and move towards a more explicit interpretation of the emergent themes (see Discussion Chapter).

The interaction between the world of the text and the world of myself as an interpreter means that slightly different interpretations could be given to the same texts by different interpreters/researchers (Ricoeur, 1981). This is why I aimed to constantly be aware of how my presumptions and own experience and views might have been impacting on my engagement with the data, and to transparently acknowledge my personal, ontological and epistemological point of view throughout this research.

#### **3.7.7. Data storage**

Each recording was transferred from the recording device to my personal laptop and on an external hard-drive for back-up storage after each interview. Each digital interview folder was titled with a different pseudonym corresponding to each participant. The laptop was locked away when not in use. All transcripts will be kept under safe storage for five years after the completion/publication of this research, before being destroyed/deleted.

#### **3.7.8. Assessing quality and validity**

Forshaw (2007) challenged the concept of validity or rigour for qualitative research, arguing that the ontological position underlying qualitative research implies the possibility of infinite



interpretations. Though this philosophical perspective partially resonates with me, I also considered that espousing a systematic evaluative approach to the research process could be beneficial.

Madill et al. (2000) and Reicher (2000) suggested that the criteria used to evaluate qualitative research need to be consistent with the specific methodology they aim to evaluate. Willig (2012) clarified that these criteria need to be able to evaluate whether the qualitative study contributes to knowledge meaningfully, based on its aims. Consistently, I considered Yardley's (2000) four criteria as suitable as they have been used broadly and are recommended by Smith et al. (2009) for IPA research. Yardley's four criteria for assessing quality in qualitative research are elaborated below:

#### 3.7.8.1. Sensitivity to context

Sensitivity to context involved myself assessing relevant literature and empirical data, and demonstrating sensitivity to sociocultural context, including "normative, ideological, historical, linguistic and socioeconomic influences on the beliefs, objectives, expectations and talk of all participants (including those of the investigator)" (Yardley, 2000, p.220). According to Smith et al. (2009), IPA researchers can exhibit sensitivity to context throughout the research process. In this chapter, sensitivity can be seen in my choice to employ IPA in line with my epistemological position and in addressing my research question in line with IPA's commitment to idiography and the lived experience.

#### 3.7.8.2. Commitment and rigour

This criterion involved myself designing and implementing all stages of the research with a rigorous emphasis to detail, transparency and demonstration of a coherent rationale (Yardley, 2000; Smith et al., 2009). To strengthen the rigour of the research, *triangulation* (a form of corroboration; Patton, 2002) was used throughout the research process. This is in order to stay in line with the ethos of IPA and to ensure that the analysis remains grounded in the data.

#### 3.7.8.3. Transparency and coherence

This criterion highlights the demonstration of transparency and coherence. As such, the reader can see the exact research process, how and why each step was undertaken (Yardley, 2008). Accordingly, throughout this research I aimed to offer clear descriptions of my research process and rationale.

#### 3.7.8.4. Impact and importance

This criterion for validity and quality is concerned with how useful, memorable (Yardley, 2000), important or interesting the reader might find the research (Smith et al., 2009). This research aims for a meaningful and useful contribution in tackling unhelpful therapeutic practice with SIGM clients. Consequently, it can be an important influence for ethical and

inclusive therapeutic practice. This, however, would “probably only be judged in the eye of the beholder” (see also ‘*resonance*’; Finlay, 2011, p.256).

#### 3.7.8.5. IPA-specific criteria

Willig (2013) recommends that the evaluation criteria should be adjusted to the methodological approach of the research. Thus, I have also assessed the quality and validity of my research with Smith’s (2011) following four IPA-specific criteria, alongside Yardley’s pluralistic criteria:

- 1) My research subscribes to the theoretical underpinnings of IPA (phenomenological, hermeneutic and idiographic).
- 2) My paper is sufficiently transparent for the reader to understand the process.
- 3) The analysis aims to be coherent, plausible and interesting.
- 4) Each theme is evidenced by sufficient sampling from the participants. A minimum of three extracts per theme is recommended for an eight-person study. I aimed for more than three, even if this is a six-person study, in order to allow the voices of my participants to be heard.

### **3.8. Ethical considerations**

As a trainee Counselling Psychologist I adhere to the ‘Code of Ethics and Conduct’ (British Psychological Society, 2018), the ‘Standard of Proficiency’ for Practitioner Psychologists (Health and Care Professions Council, 2015) and the HCPC ‘Guidance on Conduct and Ethics for Students’ (2016). As a researcher, I strive to embody ethical principles that emphasise respecting the autonomy and dignity of individuals, scientific value, social responsibility and maximising benefit and minimising harm of individuals involved in this research (British Psychological Society, 2014). Ethical approval for this research was granted by City, University of London (Appendix H). Essential ethical considerations relevant to this research are discussed below.

#### 3.8.1. Risk

Some studies indicate a higher rate of mental health (e.g., Balsam, Beauchaine, Mickey, & Rothblum, 2005) and suicide risk (King et al., 2008; Harris, 2013) amongst LGBT than heterosexual individuals. Therefore, great emphasis was given on screening and debriefing participants.

#### 3.8.2. Consent

Recalling unhelpful therapy experiences during the interview could induce some emotional distress to participants. Participants were provided with participant information (Appendix B)

and participant consent (Appendix I) forms prior to the interview. This allowed the participants to know more about what the research was about and what it would entail.

### 3.8.3. Debriefing

Unpredicted self-disclosures and unexpected narratives could occur because of the deeply personal content and semi-structured nature of the interview (Fassinger, 2005). Accordingly, debriefing and sign-posting were offered as appropriate (Appendix J) (Smith et al., 2009).

### 3.8.4. Anonymity

Any personal information was stored separately from the research data and all biographical information and profiles were altered in order to ensure participants' anonymity.

### 3.8.5. Interaction

During my interaction with the participants I remained mindful of my role as a researcher and not a therapist, in order to avoid a 'quasi-therapeutic relationship' (Willig, 2013). I strived to bracket and discuss any emerging personal/emotional reactions from the interview with my research supervisor and personal therapist.

To ensure my own safety, I always informed another trainee Counselling Psychologist of my whereabouts, before and after each interview.

### 3.8.6. Reflexive data analysis

In analysing the data, I had in mind that "the human interaction in qualitative inquiries affects researchers and participants, and the knowledge produced through qualitative research affects our understanding of the human condition. Consequently qualitative research in psychology is saturated with ethical issues" (Brinkman & Kvale, 2008, p.263). Therefore, I aimed to approach, present and interpret my data based on thorough consideration of ethical matters involved in the conduct of research with human participants (Data Protection Act; 2018; BPS, 2009; BPS, 2014; HCPC, 2015).

Consistent with IPA principles, informed consent was gained from participants not just for participation but also for the focus of the analysis (Smith et al, 2009). As anticipated, several participants shared important experiences of their life circumstances or therapy. However, if these experiences were not linked to therapy or their gay identity they were not included in the analysis. To manage this respectfully, I transparently explained to the participants the topic of interest that analysis would focus on prior to the interviews.

During the process of analysis I strived to embody ethical principles that emphasise respecting the dignity of individuals, scientific value, social responsibility and maximising

benefit and minimising harm of individuals involved in this research (BPS, 2014). Accordingly, I aimed to give voice to the sense-making of their experience without leaving the participants feeling exposed, but neither invisible nor unheard. As such, I felt ethically challenged regarding which quotes and from which participants I would choose to present. To manage this ethically but also in line with the IPA principles (Smith & Osborn, 2008) I used quotes from all participants. I aimed to present quotes that reflected and complemented my sense-making of this experience coherently. I appreciated that this enquires an ongoing reflexive process of bracketing (epoché) of my 'natural attitude' that may colour my choice of quotes at the expense of what the participants intend to express and emphasise (Langdrige, 2007). However, bracketing can only be partially achieved (Smith et al., 2009) and this is something for the reader to keep in mind.

Unlike phenomenology and descriptive phenomenological research, interpretative phenomenological research allows for the researcher to assign deeper meaning to the data. Thus, I allowed for my interpretations to be faintly influenced by my own pre-suppositions and expectations but not by pre-established theoretical frameworks (Willig, 2017). Instead, my pre-suppositions and expectations were informed by the whole of my participant's account. To ensure that I have not strayed from my epistemological and IPA framework my research supervisor provided me with feedback regarding my analysis through 'triangulation' (Smith et al., 2009).

#### 3.8.7. Inclusive terminologies

Last but not least, throughout this research I endeavoured to be mindful of and use appropriate, inclusive terminologies for my SIGM participants, in order to respect, prize and validate their individual identities (Griffith et al., 2017).

## 4. Chapter Three: Findings

### 4.1. Presentation of Findings

Following the IPA analytic process (discussed in the Methodology chapter), the following Master Themes emerged: Making Sense of Disconnection, A Rejecting Therapy for a Gay Individual, Understanding the Impact of Unhelpful Incidents Outside Therapy. These themes are presented in the diagram below, with their corresponding subthemes:



**Figure 1:** Master Themes with Subthemes

The Master Themes and the subthemes within them are the outcome of my endeavour to present a coherent account of the data. Rather than existing in isolation however, these themes can be seen as being interconnected and having been clustered in my attempt to enhance clarity in light of the research question. These emergent themes, and my engagement with the '*double hermeneutic*' process, may have allowed a narrative to arise that shows my sense-making of how SIGM experience and make sense of unhelpful incidents in therapy:

*I understood that SIGM entered therapy at a stage of their lives where they felt particularly vulnerable. They seemed to have hoped for a therapeutic connection where they could feel supported and understood as a whole, including their gay identity. However, different unhelpful incidents seem to have contributed to the experience of a disconnection with the therapist and in most cases with the therapy altogether. These incidents seem to have made clients feel like they had no space for their own individual identity in therapy. This appeared to impact their life outside therapy, particularly their relationships and how they chose to proceed in finding a way forward.*

**Table 2:** Narrative of the Findings

In the analysis section below I present and explore the emergent Master Themes (**in bold**) with their subthemes (*in italics*). My commentary, supported by raw data extracts, aims to get “as ‘close’ to the participant’s view as is possible” (Larkin et al., 2006, p.104) and meaningfully interpret my participants’ lived experiences (Smith et al., 2009). The symbol [...] suggests speech has been removed: principally my speech of asking something for clarification or if the participant moved away from this study’s topic of interest. Removing speech can imply the limitation of participants’ voices being presented in the influence of my ‘natural attitude’. My prejudices, prior understanding and my own experience of unhelpful discriminatory practices in therapy could influence which quotes I choose to present. This could alter the presentation of the experience of the participants remarkably. Therefore, care is taken to maintain a ‘phenomenological attitude’ in order to aim for enhancing, instead of limiting, participants’ accounts and for not misrepresenting their experiences. All identifying information has been altered to preserve confidentiality.

## **4.2. Analysis**

### **4.2.1. Master Theme 1: MAKING SENSE OF DISCONNECTION**

#### **4.2.1.1. “I was quite lonely”**

All six participants described how vulnerable they were upon starting therapy and their need for a supportive connection to have been of particular importance.

For example, Brian, who was a researcher at the time he began therapy, described being vulnerable and needing a supportive connection:

*“It was a very difficult point in research because it was quite a personal research... [...] So I returned to... Where I lived as a child.... Which I’ve never been back to... [...] So I needed some therapeutic support ... Just to*

*get me through that... [...] And just to ... Support me really... [...] So I went to just to... Have some support ...” (Brian: 13-32).*

Brian’s description of that point in his life suggests how “very difficult” it was on a “personal” level. Brian mentioning going back home might imply how important having a sense of ‘shelter’ and feeling connected was for him. Indeed, he later adds that he needed some therapeutic support. His repetition of “just to” could suggest that having a therapeutic bond that felt supportive was the main thing he was needing at that time to cope.

James also described being particularly vulnerable. Unlike Brian, he expressed a need for a helpful human connection that he could not get from his family:

*“It was a very difficult time... It was not, it was not easy to find a job... It was right after the crisis... Um... So... There weren’t any jobs ... Um... I was losing weight... I think I had lost twenty kilos... In, in a month and a half... I... couldn’t sleep at night... Um, there was lots of drama happening with the family, so I decided to, to step back from the drama and to just take my distances... And so I was... I, I mean I wasn’t in touch with my mom and no one in my family...I needed... [...] So... I knew I needed help... And that’s how I ended up going to the therapist... [...] So I went to see that therapist and I think I needed I, I, I really needed help...” (James: 71-112).*

James mentions the contextual factors of his difficulties, such as the financial crisis and being made redundant. He gives voice to the embodied manifestation of his vulnerability and feelings of loss. His distance and detachment from his family indicate the magnitude of how distressing even his family home felt for him. This shows how isolated James must have felt during this time. James states that he “really needed help”. “Really” can emphasise James’s urgent hope to find help for his distress and isolation in therapy.

As will be further explored in the analysis, these feelings of vulnerability and longing for connection were also emphasised with a hope of someone accepting them as a whole, including their gay identity. This seems to be apparent in Manuel’s description of starting therapy:

*“... So I was seventeen, this was the time when I first started, like discovering my sexuality for real... And for... as properly acknowledging it... I guess... As not, em... As something I really, really wanted to, to talk about... Something I wanted to ask about... And... Not just something that it*

*was a phase...or... [...] ... Because, I was quite lonely... Um... I was quite a lonely teenager..." (Manuel: 4-51).*

Manuel's last phrases echo the sense of loneliness he was experiencing at a very significant time of his development. "For real" might suggest that he was coming face to face with something very important for him. One can hear his desire to talk and feel understood. The fact that he then says "I was quite lonely" can show the magnitude of loneliness, accentuating his longing for connection and acceptance.

Likewise, Omar wanted to feel understood and supported after breaking up with his boyfriend and experiencing himself very negatively:

*"I went to therapy to feel... finally understood... Especially after I was ...feeling shit low...with my ex-boyfriend... He made me feel... so shit in the relationship... with all the diminishing... and ...and stuff... It ... It was good we ...broke up...I guess... But I was still feeling... like shit... you know? And ... And that...that's why I went to therapy... To feel...I wanted someone to understand me and, and support me...with whoever.....whatever I am,I believe...You know?" (Omar: 216 -228).*

Omar describes a recent relationship where he seems to have felt very diminished and devalued. He makes sense of himself at the time he started therapy as hoping to be understood and supported with "whoever" and "whatever" he was as an individual. His use of the word "finally" can be understood to show his prolonged and deep sense of not having this understanding and support. This is demonstrated by his use of "you know?" a few times whilst talking about this matter.

#### **4.2.1.2. "Just be a human being"**

As already expressed by James and Omar above, all participants' vulnerability upon starting therapy seemed to encompass a wish to connect with another human being in the context of therapy.

James went on to describe:

*"I was depressed at that time so... And I... Didn't know what to do, didn't know what to believe and...I couldn't trust myself... So yeah, there was something... Wrong with the sessions, where she wouldn't ... She would always talk and go in another direction. She would not get to that topic even though it's kind of heavy [...] So it was helpful in a way, because I needed help with that as well... And... I trusted her...She was a therapist... And I*



*wasn't sure what to do with myself and with my life...She was the only person I could trust around me... I didn't have... I had nothing... I had no money, I had no family support..." (James, 550-586).*

The fact that James initiates this account by saying that he was depressed at that time suggests how vulnerable he understands himself to have been at the time of therapy. One can only speculate how important it was for him to feel understood by and connected to someone else. Yet, he describes a therapist who "always talks" and misdirects the session. James seems to imply that this left him alone with a "heavy" load on his shoulders. It seems like a paradox that James mentions this interaction to be helpful still. However, "helpful" could make sense considering his subsequent words of how almost desperately lonely and in need of a connection with another human being he was. "I had nothing", he says, after referring to his therapist as "the only person" around him.

Omar described his hope of connecting with someone who could understand him:

*"I wanted my therapist to be able to understand me. So... I have asked if it was possible to have someone who is gay... Or lesbian...I didn't care... And... And who is from Asia as well. I just wanted to feel I will be with someone who would understand me...you know?" (Omar: 17-23).*

Omar clarified that he asked to be seen by someone who was also a sexual minority and Asian. Omar described how much he wanted to connect with someone who could understand him. This could also imply a profound anxiety about not being understood. His effort to choose a particular therapist could indicate how much he was longing for a connection where feeling understood was all he "just wanted to feel".

However, Omar elaborated:

*"...It left me feeling...like I said...shit...Like I don't ...nobody can understand me...I'm bloody alone and alien in, in this world, you know? ... It was...it was like ... I don't know... I felt... I was like an alien... another... From another planet, you know? Yeah...Like...who is ...who is with me in...in what I'm going through?... (long silence)." (Omar: 240-247).*

Omar's sense-making of the experience of not having this understanding connection may show exactly how much he was longing for it. His statements of "nobody can understand me", "I'm bloody alone and alien" very powerfully illuminate his experience of total loneliness and disconnection from the world and even his therapist. This shows how rejected he felt but also how strong his hope for connection was, as if he was wishfully wondering 'perhaps on another planet there is someone who can understand

me and I can feel accepted'. His long silence following this description could indicate how emotionally charged this experience was for him.

Thomas also described how very lonely he felt and the significance of having a person to connect with upon starting his therapy:

*"... I didn't know at the time... But I have been thinking about it now, why didn't I leave... And I think the honest answer... I think... Comes down to that ... So I've moved to London after I ended my relationship... I'm not from London, I'm not from England... And ... I didn't know anybody here... I don't have friends or family here... He probably was the one consistent person that I had... On a weekly basis... And I think I was afraid to ... Let go of that in some way... [...] I know certainly back then because I was ... I was fairly new in London and... ... I felt very, very incredibly lonely... So, I didn't... Like I said, I didn't know people here..." (Thomas: 795-814).*

Thomas explains that at the time of his therapy he did not know what made him stay with his therapist even though he wanted to leave. Now, he understands that this must have been because he was not connected to any other person in London. Perhaps similar to Omar feeling like an alien, Thomas' consistent connection with his therapist was the only thing that was keeping him from feeling completely alienated in his new city. And similar to James, so strong was his longing for this human connection that even if it was not satisfied with his therapist Thomas would feel "afraid" disconnecting from him. Thomas' expression of how "very, very incredibly lonely" may illuminate his profound need to connect to his therapist as another human being.

Chris's longing for human connection can be heard in his expressed frustration in not having this need met:

*"... You know, sometimes I came and said 'I don't know what to talk to you about, today'... And I'd sit there and he'd say 'Oh so you just said that you didn't know what to talk about today'... And-and it happened every session... And I'd say 'stop being fucking Carl Rogers, just be a human being'. I don't want to have a mirror, otherwise I'd pay myself money and look in the mirror..." (Chris: 412- 419).*

Chris describes an example where he made sense of his therapist's responses as repetitively non-engaging. Throughout the interview he seems to understand the person-centred approach as responsible for this machine-like interaction. Though one could argue how this is the very opposite from what person-centred theories ascribe to, Chris

seems to be saying that he was deeply hoping for a human connection but something inanimate was interfering with it: either a theory or a mirror, and certainly not a human being. Perhaps “just be” in “just be a human being” suggests how simple yet essential was the concept of humanness in the connection Chris was seeking with his therapist.

#### **4.2.1.3. “It’s not really being very connective”**

All participants hoped for a human connection, however all of them described a subsequent experience of disconnection.

Brian sensed a therapist that was not “very relational” to start with:

*“And he seemed, he seemed very... He didn’t seem very centred or grounded [...] or... Very relational...” (Brian: 60-61).*

Brian appeared to experience the contrary of the relational therapist he wished for. He then described his experience of an unhelpful incident, when the therapist self-disclosed about his own heterosexual relationship. Brian understood this as rather unnecessary in the therapeutic context:

*“...Part of me was thinking... Why is he saying that ... Is he saying that because he is kind of... He is identifying me as... Well, he knows I’m gay because I... You know, I identify myself as gay... [...] So is he saying that to distinguish himself as not being gay? [...] And why would he do that? [...] So he sent... Why would he sent that message? [...] Does this relate to the fact that it’s... It’s not being very relational, the therapy... [...] It’s not really being very connective...” (Brian: 105 -118).*

Brian was confused by his therapist’s disclosure and he struggled to make sense of it. Asking whether his therapist said that to distinguish himself as heterosexual suggests how he felt this disconnection may be linked to his sexual identity. It also suggests an experience of separation and disconnection in the therapeutic relationship. This becomes clearer when Brian contemplates whether the therapist’s heterosexual disclosure was related to therapy not being relational or connective to start with. The fact that he ascribes ‘therapy’ to lack a relational and connective experience can echo the experience of the lack of another human being in the room; it was Brian and the therapy, not Brian and the therapist.

However, he links this sense of disconnection with his therapist’s traits and discomfort around Brian’s sexual orientation:

*"I mean it's possible that he is just... Not a very good therapist... [...] Who just says things about his private life... [...] That's possible... And it's possible... That he's quite an anxious person... And, you know... He's not very good in sort of being centred and relational... [...] So that... That's the interpretation... Um... I think on balance, my interpretation was that... Yeah, he was just, you know... Not, not, not comfortable... [...] and not entirely comfortable with me as a gay man..." (Brian: 315-328).*

Brian now explores a range of possibilities about his experience of disconnection with his therapist. I sensed his interpretation to diffuse a stream of emotional anger. Perhaps this could be understood as Brian now getting in touch with his feelings of disconnection with another person, his therapist, and not the therapy. When referring to the therapist being uncomfortable with him as a gay man he repeats "not" three times and then adds "not entirely comfortable", indicating difficult feelings around not feeling accepted by and connected with his therapist because he is a gay client.

Chris also described his therapist as not encouraging a relational connection to start with. Similar to Brian, he experienced a disconnection that he understood to be due to his therapist's discomfort around Chris' gay identity:

*"I felt in a way he didn't give a damn about me... And it was ... 'Come in, do fifty minutes'... You know, he'd say 'Oh you got to do fifty minutes, go'... And then I'd pay and that was it... It just felt ... felt very corporatized... You know... There wasn't any human interest in it... [...] I didn't feel that there was a human that I was dealing with... [...] I didn't feel respected at all... As I said I felt judged ...And disavowed... by him."*  
(Chris: 1421-1443).

Hearing Chris talking about a "corporatized" relationship can give one the image of a machine-like interaction. Furthermore, it seems that Chris felt dehumanised by this ongoing experience of disconnection. That Chris mentions feeling disrespected and judged and the therapist not giving a "damn" about him can show the magnitude of a rejecting experience of disconnection that can be precisely termed by Chris's use of the word 'disavowed'. This word also echoes Chris's understanding that his therapist's disconnecting stance was because of Chris' gay identity. Indeed, throughout his interview

Chris talked about sensing a judgmental and rejecting stance from his therapist towards his gay identity.

So disconnecting it felt, that Chris (earlier in the interview) shared having to disconnect with therapy altogether and leave it prematurely:

*“I, I left the last session after only seven minutes... [...] Because of how he was with me... And I’ve never walked out of therapy... Ever... I don’t think I have ever walked out of a meeting... ever [...] And I was so angry that... He was not listening to me and ... ... Understanding me... [...] There was no relationship... I didn’t even feel that... he understood me... I felt that he didn’t give a shit about me...” (Chris: 130-155).*

Chris emphasises how he has never walked out of therapy. This indicates how overwhelming this ongoing disconnection must have felt for him at that instant. Throughout his words in the two passages above, Chris mentions the therapist not giving a “damn” or “shit” about him. This repetition suggests an experience of feeling so worthless in the eyes of someone who does not even try to understand him. Not only was there “no relationship”, but there was a very devaluing experience of disconnection it seems.

Similarly, James also physically disconnected from therapy prematurely as a response to hearing his therapist’s stance that being gay is the result of traumatic life events:

*“And... That’s when she said explicitly that’s the way she sees the world... That we are not necessarily born the way we are... [...] And that was the last time I went to see her...” (James: 457 -480).*

James describes this disconnection as a gradual build-up of his mistrust in her and her capacity to help him:

*“It took me a little bit of time and... I was getting to the idea that I couldn’t trust her... It wasn’t suddenly [...] I... Didn’t wake up one morning “oh I can’t trust her”... I mean it took time, so... I was preparing myself for it... And then when I finally... When I had the final answer.... I was... Argh, “oh my God”... I was a little bit shocked...” (James: 701-710).*

In his speaking about the broken trust, there is a notable contradiction in James saying, “it wasn’t suddenly” and “I was a little bit shocked”. It seems that James sensed the mistrust from early in therapy but found her “answer”, referring to her stance on being gay as a

choice, significantly shocking. The “final answer” may indicate just how much James had been questioning his relationship with his therapist. Perhaps it was hard to accept the disconnection between them and to leave therapy earlier.

This “shocking” incident felt insulting for James and his relationship with his therapist:

*“It was... Insulting to hear. [...] We had been talking for months... And for months... I was getting to... I mean... She knew who I was... We talked a lot... And then... She... It felt insulting... I think I've felt insulted... And it wasn't a good feeling being insulted by someone you trust...” (James: 852 -860).*

James says “insulting/insulted” four times. This indicates the magnitude of the insult James felt after the incident. James describes having “talked a lot” and feeling “insulted by someone you trust” and someone “you think has been helping you”. This can feel as if his longing for trust and a supportive connection, which he had in fact felt with his therapist, was in turn ruined by his therapist; he was betrayed.

Thomas also felt the unhelpful incident interrupted the relationship he had already built with his therapist:

*“This probably would have occurred... Quite a few months into therapy... So I think we had established a decent enough relationship...” (Thomas: 17-19).*

Thomas described how his therapist, who also identified as gay, expressed some rather judgmental stances and presumptions. Thomas understood these presumptions to be linked to him talking in therapy about his unconventional sexual activities in his previous relationship. He therefore struggled to open-up in therapy, disconnecting from therapy as a result:

*“It was unfortunate that... That that did happen, because there were... There were definitely, since then other things that have come with my personal life that... I felt like I could never share with him, I could not talk to him about... And ultimately ...That's when I decided to end the therapy”. (Thomas: 306-314).*

Thomas gives us a glance of what this incident and process of disconnection felt like here:

*“I remember feeling quite afraid... It's the world I'd use... I think... (Sigh)... This... The incident... Plus just how staring that he looks... He doesn't often smile for example... So... It was fear and feeling afraid...”*

*Which is not good, you shouldn't go to therapy and feel afraid of the therapist....I definitely, definitely felt fear... Felt afraid and felt... I think I would... The only way I could describe it is... Fear of... Fear of judgment... Maybe fear of... His tone and his domineering... Of him changing... And becoming quite angry... Or... Forceful in some way... As well as feeling afraid that my shame ... My internal shame...Would come out and be exposed or that I would be left feeling very exposed... And, and humiliated in some way..." (Thomas: 969-1001).*

Thomas emphasises that he "definitely" felt "fear" with his therapist following the incident. Thomas repeats "afraid" and "fear", indicating the prevalence and intensity of this emotional experience for him. His description of his experience of feeling "exposed" and "shame" and "humiliation" with a non-expressive and judgmental therapist can imply a feeling of a sharp and cold sense of disconnection. A disconnection that seems to have left him feeling vulnerable, helpless and alone in the presence of a domineering, unpredictable, aggressive and humiliating therapist.

Despite this intense experience of disconnection, Thomas felt "trapped". Unlike the other participants he remained in therapy, even though he wanted to leave:

*"I felt trapped....I felt like I was trapped in therapy because I kept saying I wanted to leave... But he was not hearing any of that... But I felt trapped I guess in my own head as well, because I was thinking [...]... 'Do I want to be in this relationship, do I want not'... It's the same in...with the therapy relationship... But... Outside I was asking lots of questions ... And people were saying 'Hey you...Sounds like you have a very passionate relationship'... 'Sounds like you fight a lot'... And I was 'Wow, is this what is supposed to happen in therapy?'..." (Thomas: 1205-1238).*

Here, Thomas describes his confusion of whether or not to stay in this relationship with his therapist. The word "trapped" seems to indicate Thomas' internal conflict of feeling disconnected but finding it very hard to leave. It seems that only by talking to other people about what was happening in therapy, did it become clearer to him that he wanted to leave. Both the above two quotes from Thomas' interview and the mentioning of fights in therapy, vividly portray a sense of detachment and separation between his therapist and himself, whereby they cannot reach each other, with him thus experiencing confusion and anger.

#### 4.2.1.4. **“Keep going to hopefully feel better”**

Regardless of the experience of relational disconnection, all participants reported continuing to see their therapist.

For example, Omar said:

*“It makes me feel so angry you know? [...] I was more feeling so confused and ...a bit...like no one can understand me... I felt frustrated...Yes... It was... Frustrating...But I wasn’t angry... because I thought it was me. I thought I was alone and I was...I wasn’t worth it you know... Yes...worth being understood...or something like that...” (Omar: 266 -276).*

Omar describes feeling angry now. However he contemplates that back then, following the unhelpful incident, he felt frustrated and confused about not feeling understood. He makes sense of this emotional confusion, reflecting upon his own lack of sense of worth at the time. Despite this negative experience, Omar reflects on the fact that he kept going back to see his therapist:

*“I was confused... So... I was feeling something (places hands on his chest)...but I wanted to keep ... to keep going to hopefully feel better... I felt.... like worrying... and that something is wrong... But... I wasn’t sure if it was me... If there was something wrong with me ... Or with what is going on... So I wanted to...to keep going back to...to see...to feel better.” (Omar: 327 – 340).*

Omar still remembers that experience as something within his body. This can show how visceral this experience was and perhaps too difficult to put into words then. Omar’s confusion can illuminate an internal battle in seeing this therapist: on the one hand he did not feel understood as a gay man and he felt disconnected from his therapist, on the other hand he wanted to keep going back to “feel better”. “To feel better” can show Omar’s persistent yet unfulfilled hope for reconciliation. This hope can also be implied when Omar wonders if there was something wrong with him. Perhaps by placing the “wrong” within himself, Omar was hoping that he could resolve the disconnection with his therapist.

Chris also described not feeling understood by his therapist throughout his interview:

*“I didn’t even feel that... he understood me... I felt that he didn’t give a shit about me...” (Chris: 154-155).*



The use of “a shit” here indicates how mistreated Chris felt. Yet, he would still go to see his therapist. This is also reflected here:

*“I’ve put up with ...enough really... I felt quite ...am...I don’t know, I felt really like he didn’t give a damn about me...” (Chris: 216-219).*

“I’ve put up with enough really” suggests that Chris now sees that he had “put up” with feeling mistreated by his therapist for a long while. “I’ve put up” can show the internal battle Chris was experiencing during his therapy. Perhaps similar to Omar, Chris felt disconnected from his therapist yet he kept going back. Also similar to Omar, Chris says:

*“... It was quite, it was quite a horrible experience [...] Friends of mine, used to...you know colleagues of mine used to say ‘Why you keep seeing him?’...And I said... Well, I wondered if it’s a resistance...I wanted to try to work through the resistance [...] Is it my resistance?” (Chris: 365-381).*

Here, one can hear how much Chris was willing to keep going back to see his therapist. Perhaps understanding this “horrible experience” as his “resistance” was helping Chris to “put up” with not feeling understood as a gay man in therapy. Maybe this was preserving a hope of feeling understood by and connected to another; his therapist.

Brian described his decision to keep going to therapy despite an unhelpful incident that he experienced:

*“I kind of thought, well ... I’ve done four sessions... I’m just going to stay with it for another four [...] Just to kind of work it through...” (Brian: 192-200).*

Brian understands that he intentionally stayed in therapy following the incident as he was hoping to “work it through”. The fact that the incident took place half way through the therapy suggests that Brian may have already established some connection with his therapist. This may have nourished his hope that a conciliation could happen.

Later, talking about his other “good” therapy experience, Brian says:

*“... If I look at good therapy... It’s been about... Challenging rejection, others’ rejection and I mean challenging my own rejection with my sexuality...Challenging my internal homophobia... So a lot of my therapeutic work has been about... You know, taking on the rejection... Challenging it and accepting myself... So when you get something like that it’s kind of, sort of like going backwards really... [...] It sort of takes*

*you back to.... Thinking that actually there is something to reject...Probably... So it sorts of taps into very early feelings of low worth... And shame and... You know, being worthy of rejection...”*  
(Brian: 841 - 869).

Brian’s description of his previous “good therapy” totally contrasts with the other unhelpful therapy experience he talks about in his interview. So rejected Brian felt in this experience that it took him a long way “backwards”. This elicited emotions of low worth and shame.

Both “shame” and “worthy of rejection” can bring a vivid image of Brian perhaps feeling so worthless that he wanted to hide, or that he deserved to be marginalised and exiled by another, even his own therapist. However, he chose to stay in this therapy. This indicates Brian’s emotional struggle during this experience of disconnection in therapy. His willingness to stay can show his hope for things to eventually feel better.

Likewise, James described how he continued seeing his therapist, even though he “should have been angry at her”:

*“Um... (Silence). I’m not angry at her... I don’t have anger... She... Should have done things differently... She, she was... I’m not angry in... [...] I’m not sure how I feel... Um... It’s hard to put words on feelings... And to describe them... [...] I should have been angry at her... Because she... Made me feel bad about something that I shouldn’t feel bad about... When... She said that it wasn’t a big deal and that other kids are going through that... Even though it was... And it still is... A guilt that I have... I felt angry because I was allowing myself to feel that... But it is normal to, to think that way... It shouldn’t ... She should have... She shouldn’t have made me feel that way... I should have been angry at her...”* (James: 1116-1182).

The silence in the beginning of this quote may suggest how confused James was and still is about how he felt with his therapist following an unhelpful incident in therapy. This is reflected clearly when he shares that he is not sure how he feels and how to put his experience of it into words. James saying “I’m not angry” sounds as if he is responding to an internal conflict about whether he now feels angry at her or not. This internal conflict seems to acquire a voice when James describes an incident where his therapist trivialised his sexual abuse as a child, something that sounds outrageously unacceptable. On a cognitive level, James knows that he “should have been” angry at his therapist’s statement. However, he is not conscious of an experience of this anger on an emotional

level. He does speak of his experience of guilt for feeling badly about something he “shouldn’t feel bad” about.

James repetition of “should” can show this ongoing internal battle between his cognitive and emotional experience regarding what was happening in therapy. It is as if during the time of the therapy he wanted to keep believing in his therapist and not feeling angry at her. This can show how much faith James was putting in a therapist who actually betrayed him. It also seems to reflect what all participants describe: a hope to feel better by continuing to see their therapist and a hope to finally be understood by someone.

#### **4.2.2. Master Theme 2: A REJECTING THERAPY FOR A GAY INDIVIDUAL**

##### **4.2.2.1. ‘Gay-blind’ therapy practice**

I generated the ‘gayblind’ term from the analogous term of ‘colourblind’ in relation to racism. All participants seemed to have perceived their therapist as dismissive with regard to how being gay impacted their individual experiences.

Manuel expressed this here:

*“She seems to be the kind of person who thinks ‘Oh well’, you know, ‘I took a lecture on equality once’... ‘I’m friends with a gay couple and my daughter’s teacher is a lesbian, so I’m totally fine with this... ‘And know all about it’... Which is not... Kind of... Stick to her own kind of... Privilege that she... I think it’s okay to ... I think that would have been an... A sort of... A response I would expect from someone my age...” (Manuel: 236-249).*

Manuel’s use of “oh well” can indicate that he experienced his therapist as someone who does not take seriously how difficult it is to be gay for him. Manuel perceived his therapist as someone who assumes to “know all about it” and who is not willing to listen and value Manuel’s own experience of being gay. On the contrary, she “sticks to her own” understanding: an understanding that is blinded by her “privilege”. The use of the word “privilege” suggests that Manuel perhaps experienced his therapist as diminishing and as discriminatory towards his gay identity. He feels disappointed by a therapist who seems to lack essential awareness of her role and responds as Manuel would expect a 17-year-old teenager to (this is how old Manuel was during this therapy experience).

Manuel then describes a dismissive therapist who was not willing to listen and value Manuel’s experience of being gay:

*“I don’t care about what you think... Like, I don’t care about your take on this ... What I was looking for? As I’ve said... reassurance... A place to...”*

*Have, I guess, release of the things that I am not able to talk about with anybody else ... And my frustrations and my fears... To do with my sexual orientation ... [...] Fears I had then would be, you know, being seen as a token or...stereotyped [...]... It does make me very angry.” (Manuel: 576-607).*

Manuel seems particularly angry here, explaining how his therapist's stance on gay matters in his therapy was actually irrelevant to him. Manuel felt he could not talk about his fears and frustrations in relation to his sexual orientation with “anybody else”. This suggests a profound longing to talk about these matters with someone freely whilst feeling reassured instead of being discriminated against or “stereotyped”.

In contrast to Manuel, Omar felt that his therapist had a historical and political awareness on gay matters that he found helpful:

*“He was very gay supportive, with gay stuff too... He was... He knew lots of things about gay history... political matters... And, and helped me... (Omar: 66-68).*

However, Omar then describes:

*“It’s strange... Because he never told me if he was gay...He never told me... ‘I am gay too and it is okay to be gay’... It was like he was hiding it almost... [...]. He didn’t tell me the thing I wanted to hear...to feel confident that it’s okay to, to be gay. To give me the supportive message with the... He would speak about gay politics but I... I felt he was hiding his gay identity almost.... I’d rather he had said ‘I am gay ... and it is okay to admit ...To say it.... Well, definitely that [...] But what was the most unhelpful thing...going back to ... To him taking space... to... Taking the space for himself... The annoying and strange thing is... He never owned his sexuality...” (Omar: 108-130).*

Omar seems to have hoped for his therapist to share his sexual identity. “The thing I wanted to hear” suggests how important this disclosure would have been for Omar. So important it was that he would even prefer it instead of the aforementioned information regarding gay matters that he described as supportive. Here, perhaps Omar is talking about wanting his gay identity to be understood in a humane and relational manner, beyond any intellectual information. What Omar finds confusing is that his therapist would use all “the space for himself” to talk about political matters yet not mention his own sexual identity. Omar appears to understand this as his therapist “hiding” his gay identity.

Similar to Manuel, Omar seems to describe his therapist as almost being blind to what Omar would “definitely” find most helpful for embracing his gay identity, leaving Omar feeling annoyed.

Thomas spoke explicitly about the feeling of shame being perpetuated by a therapy that did not validate his individual gay identity:

*“Because part of my struggle I think has always been ... Something to do with shame in relation to being gay... Shame in relation to sex... Shame in relation to... I don’t know... Particular sexual activities that I... I might have enjoyed... Those kind of things ... I felt that these could not be... These could never have been discussed in therapy... Ever... After what had happened... I mean... I thought that him being gay... Would have somehow made it easier [...] But I found it much more difficult...” (Thomas: 616-682).*

Thomas describes not being able to address his shame in relation to being gay even with a gay therapist. Earlier in the interview Thomas mentioned how he experienced his therapist as very judgmental towards his sexual activities. Consequently, Thomas felt that sexual matters could “never” be discussed in therapy. The absoluteness of the word “never” indicates how very strongly Thomas felt that his individual way of being a gay man was not accepted by his therapist. Thomas was hoping that a gay therapist would make it easier for him to ‘just be’ and talk about anything he wants in relation to his sexual identity. The expression of “much more difficult”, thus not just more but much more difficult, can show the magnitude of difficulty Thomas experienced.

Thomas, again spoke about his gay identity not being acknowledged in therapy later:

*“Because for a long time I thought I need to be in therapy... In a new therapy with someone that I can talk about all of myself and not have to compartmentalise... Yeah... (Sigh)... (Silence) (Sigh)... Do you know, I always thought that it was easy to go to a therapist and just talk about anything [...] And I feel a bit disillusioned with therapy...” (Thomas: 1426-1450).*

His use of word “compartmentalise” indicates how his therapy was blind to him as a whole gay man. After other therapy experiences Thomas hoped that a gay male therapist would be able to see and validate his individual gay identity. Thomas’ sighs and silence seem to indicate how disappointed Thomas feels for having this hope broken.

Brian talked about his own experience that reflected a ‘gay-blind’ practice. He said:

*“The thing that I took away, that stayed with me is... You know, he suggested that I might not be gay... But whether I was a repressed heterosexual... A repressed heterosexual... So that was he... He actually said that... [...] Completely different to this woman who had been very... Supportive... You know, affirmative... [...] ... It was such a great experience and it was really life changing... [...] Yeah she was really good and in just six sessions... She worked really hard... She was very gay affirmative... Really positive... Really useful stuff around sexuality and sex...” (Brian: 513-582).*

Brian recalls his therapist’s interpretation about his gay identity shocking him so much that it has stayed with him to this day. “He actually said that” can indicate how Brian still finds it difficult to believe what his therapist stated then. Brian compares this unhelpful experience to another helpful experience he had in therapy. Perhaps he makes that comparison to make sense of all the helpful elements that were missing from the unhelpful therapy experience: support and affirmation about his gay identity. “Such a great experience”, “really positive” and “really useful” indicates how vital and important it was for him to have this affirmation. So much did he want a gay affirmative therapy experience that, once he had it, it was “life changing”. This helpful experience is described as “completely different” from his unhelpful one.

Later in the interview Brian says about his therapist:

*“I just think he probably hadn’t had any diversity training... Didn’t really have any gay clients... And you know... Maybe... He maybe had some issues or insecurities around his own sexuality ...” (Brian: 1174-1180).*

Here, Brian strives to make sense of his therapist’s aforementioned lack of sensitivity when working with him as a gay man. In doing so, he mentions his therapist’s lack of diversity training and relevant experience and also his therapist’s seeming insecurity around his own sexuality. Brian’s description can evoke the image of a person lacking the visual capacity to see him clearly, as he was. This left Brian and his individuality as a gay man unseen in therapy.

#### **4.2.2.2. “It is not okay to talk about this stuff”**

As explored above, all participants shared an experience of not being validated as gay men in therapy. This appeared to result in silencing them from talking about important matters, particularly regarding their sexual identity.

For example, Brian said:

*"It was at a half-way point when the incident happened... It appears to be a minor incident... But then it made me review the previous sessions... It probably inhibited me to some extent in the remaining sessions [...]... I think it probably didn't make want me to open up any more. Or... Be open about myself as a gay man... And it just left me with a question and a doubt [...]. Looking back I wish I would have said... I wish I had said... You know, 'I wonder why you tell me you are going for holiday with your girlfriend'... 'That seems quite important for you'... You know, curiously... I'm saying this now but I didn't at that time" (Brian: 187-220).*

Brian describes the unhelpful incident as taking place halfway through his therapy. The fact that he initially refers to it as a "minor" incident but then as one that made him review his whole therapy suggests how confusing and shocking this experience of rejection might have been for Brian. Indeed, he later goes on to mention how it left him with a "doubt". Brian describes this experience as so strong that it "inhibited" him from being able to be himself as a gay man in his therapy. The fact that Brian mentions finding it difficult to open up about his sexual identity and not being able to challenge his therapist at that time can give the sense of someone being paralysed and shut down. "I wish I had said" indicates how closed down Brian may have felt himself to be following the incident. Perhaps it also indicates how Brian now feels disappointed and frustrated about having been silenced as such.

Brian later mentions:

*"I think as a gay man... Over the years... From, you know, early childhood... These micro-aggressions is... Well, micro-rejections probably more than micro-aggressions.... It's just this... It's the cumulative subtle forms of it. [...] Rejected by therapist is a... It's sort of... I think that initially it's just like a closing down for me..." (Brian: 800-869).*

Here Brian makes sense of his experience of the rejection by putting it in the wider context of accumulative micro-aggressions he has been exposed to as a gay man. The fact that Brian uses 'micro-aggressions' to say 'micro-rejections' can show how 'aggressive' and thus intense this feeling of rejection was for him. "Just like a closing down" can give the sense that Brian had his last hope for acceptance let down.

Chris appears to make sense of not being able to talk openly in therapy as the result of feeling judged and dismissed:

*"I didn't feel that there was any point in talking to him about things... Really....In detail...About things... about my sexuality ... about my journey... about ...you know, wanting to be with the partner and who I'd like to be...and ...I felt...There was no point ...Because he... I mean.... I felt very judged about being gay... It was his approach...It, he was very dismissive (sigh)...you know? Um... Yeah... So why talk to somebody?" (Chris: 450-465).*

I felt that Chris described a paradox whereby he did not feel able to talk in a therapy that relies on linguistic exchanges. Chris saying "really" perhaps suggests how difficult it is for him to process this paradox. He repeats "no point" twice. This seems to emphasise how very rejecting and silencing his whole experience of therapy was. Chris highlights the word "dismissive" and then he sighs. This suggests how very bothered Chris still feels about this dismissiveness and silencing from talking to his therapist about his journey of being a gay man.

Chris seems to understand this "dismissive" approach as a rejecting attitude towards people who are gay:

*"...But if you can normalise that and that's okay to talk about... Then you can go into more delicate...More... More difficult issues... But I just didn't trust him even with that surface level...So there was no way...That I was going to talk about other stuff..." (Chris: 681-697).*

Chris contemplates about how his therapist's lack of an accepting attitude made him feel unwelcome to talk about "delicate" material. The word "delicate" suggests how valuable Chris feels his personal journey as a gay man is. However, in the context of what he is describing, "delicate" could also account for how sensitive and vulnerable he felt as a gay man in therapy. Chris seems to express his need to therefore protect himself in this therapy. So unsafe he felt that even "surface level" material would be shared with caution in therapy.

Manuel described:

*"At the end of the session, I just said.... 'Well, you know'... 'Plus, like, at school'... 'You know, for example people...', just to use an example, 'people just... Just throw the word 'gay' around like it doesn't mean anything...' [...] '... Or it means 'stupid''. And her sort of response was... 'Oh, really? I mean now? I can see that would happen when you were like thirteen, but I can't see it is happening at seventeen....'. 'Oh well, what do I*



*know?', she sort of shrugs... And then ...That was the end of the session... And it's very minor... But it is effectively, it's like a closing down of the conversation .... Like she can't stand to listen to... To something that it's not actually that big of a deal ...Well, it is a big deal..." (Manuel: 75-98).*

Similar to Chris' experience, Manuel's example of feeling discriminated at school was described as being met with dismissiveness by his therapist. Similar to Brian, he describes this incident as minor, yet as very effective in closing him down. Again, this indicates how confusing and maybe shocking this therapist's response was and still is experienced by Manuel. Manuel mentions twice that his therapist's unhelpful response was at the end of the session. Perhaps this repetition indicates how Manuel still feels his therapist's response did not leave him space to express himself. "Like she can't stand to listen" can evoke the picture of the other person (his therapist) defensively covering her ears with her hands and rejecting any effort by Manuel to open up about his difficulties. "Well, it is a big deal..." indicates Manuel's ongoing struggle to make sense of his therapist's dismissive and rejecting stance towards something that felt profoundly painful and important to him.

Later in the interview, Manuel elaborates on how his therapist's stance closed him down:

*"I think, the effect on me was that it just taught me that I couldn't talk to her... I would have to choose my words... If I were to talk to her about homophobia, I would have to pick my words incredibly-incredibly carefully... And second guess what I was saying... Which is really unhelpful [...] I've never really... I don't think ever since I've really felt comfortable talking about it to... A professional... I think I would assume that if they weren't gay they... That would just hinder their understanding... (Silence) And that their response would be similar..." (Manuel: 324-388).*

Perhaps Manuel's use of the word "taught" indicates how this experience felt like a very unfair punishment whereby an authoritative therapist made him feel powerless and even scared. The repetition of "incredibly" careful and then the use of "second guess" can portray the image of a soldier being in a state of a war-zone and having to very carefully calculate his movements in order to not be attacked by an enemy. Perhaps it is no wonder then that Manuel expresses having felt mistrust towards any professionals unless they were gay. It is almost as if Manuel felt that unless the professional was in the same team as him, thus gay, they would be dangerously unhelpful in relation to his gay identity.

Unlike Manuel, Thomas described a rejecting and silencing experience with a therapist who was also gay. He previously mentioned how he perceived his therapist to reject his

wish to explore other than conventional/traditional ways of having a romantic relationship. Thomas then said:

*"I haven't felt comfortable about talking about sex in therapy to begin with ... Even though he was a gay man... I was a gay man... We both knew that about each other... I still... Regardless of him being gay ... Probably I would find it difficult to talk about those sorts of issues... In therapy... But I felt that it was something important that I wanted to discuss with him ... And I wanted to try and understand it ..."* (Thomas: 87-103).

Thomas describes experiencing a difficulty in talking about sex "regardless". "Even though" suggests how Thomas was hoping for at least a gay therapist not to judge him discussing these matters. Thomas seems to emphasise both his difficulty in talking about his sex-related matters with his therapist and also how much he wanted to talk about them. This can imply feelings of frustration and disappointment, especially as he describes these matters as "important" and something he wished he had understood in his therapy.

Thomas then says:

*"Back then... And now... I do think what he was trying to communicate was that... Um... It is not okay to talk about this stuff.... That he maybe doesn't need to know the intimate details. [...] It was like he put up a barrier. I felt like there was a barrier there. Any further discussions after that in relation to sexual issues... Anything to do with sex, anything to do with relationships ... I've not been able to discuss anything related to sex relationships in any sort of details since then."* (Thomas: 195-226).

Thomas makes sense of his therapist's approach towards his sex-related matters as a rejecting effort to silence him. Thomas' description can portray an image of a person (his therapist) building a thick wall, a "barrier" in order to reject and not hear Thomas. It shows a rejecting and disconnecting dynamic, whereby Thomas was left feeling unheard and unsatisfied. "I've not been able" can show how very much Thomas wanted and attempted to open up about these matters that were important to him, yet this barrier has continued to profoundly impact him, disabling him from doing so.

#### **4.2.2.3. No space for client in therapy**

Not only did all participants describe being silenced by an experience of rejection around their sexual identity, but they also described their therapeutic space being intruded upon and taken up by their therapist's material.

For example, Brian perceived his therapist to intrude on his space with a self-disclosure about going on a holiday with his girlfriend. Brian experienced this disclosure as an “unhelpful experience” and as “inappropriate”. Brian shared the following:

*“I think that therapeutically as a client I don’t want to know too much about the therapist’s life... I don’t want their life to take up too much space... It’s about me... So... Then bringing other people into the room... It’s not really helpful... They bringing their relationships into the room... They are taking up psychic space... [...] In that context it feels like there is... You know, it’s selective information... And it appears, you know, that it potentially it has an agenda...” (Brian: 1069-1086).*

Here, Brian seems to emphasise how non-therapeutic and intrusive this disclosure was as he experienced it taking up his space. “Too much” indicates the magnitude of the sense of intrusion, so intrusive it felt that it was like bringing other people into the therapy room to take Brian’s space. “Psychic space” seems to illustrate how deeply and internally this intrusion was experienced. Moreover, “selective information” can echo how very personally Brian took this disclosure and still does. Brian senses this disclosure as potentially having an “agenda”, perhaps something intended to take his space in therapy by targeting him and his sexuality.

James also described his therapist’s views as occupying his space in therapy:

*“... And she kept implying that events in your life can turn you gay... And... I would disagree with that... And that’s how it came out... That she was seeing that... I mean she thought that something can, something can turn you gay... And according to the event that happened in your life... Or anything... And ... I thought ‘this is, no, this is, I can’t continue’... ‘I can’t continue in this situation, because that’s exactly what brought me here’... And, and this isn’t the way I wanted to go...” (James: 426- 449).*

James repeats his therapist’s view that “something can turn you gay”. This shows how disturbing it was for James to have such a response. From what James is describing there is a sense that he experiences his therapist as having interrupted him from his exploration and almost contaminated his space with an opinion that felt totally wrong to him. This is reflected strongly by James repeating “I can’t continue” and “this isn’t the way I wanted to go”.

James later expands:

*“That’s when she said explicitly that the way she sees the world... That we are not necessarily born the way we are... That events in your life can make you the way you are... And, and I asked her... Then I asked her specifically... About sexuality and so... She said ‘yes, I do believe so’ [...] And that was the last time I went to see her... (James: 457-480).*

This quote echoes how strongly James felt that there was no space for him as a gay man in this therapy and he left. James seemed to understand his therapist’s views as not validating his existence, not seeing who he is in therapy and therefore not giving him the space to be.

Manuel also describes his therapist’s opinions leaving him with no space for him in therapy:

*“... I didn’t go there to be shuttered down or talked over... Or condescended to... And... I think, you know, her kind of questions ‘but why does it, but why does it bother you?’... Um... Given everything else, it’s a bit misguided, because it would be nice if she had an idea of why ... She won’t have to assume without.... Assuming ... She also would sometimes bring it up... When I haven’t talked about it, she would bring up and would talk...” (Manuel: 909-928).*

Manuel’s account can give a sense of him trying to claim a space in therapy to explore what it is like to be gay and in his late teens but his therapist “shuttering” him down, talking over him and being condescending instead. The word “condescending” suggests that Manuel felt patronised and invalidated. It is almost as if this experience left him feeling unimportant and pushed away from his space in his therapy. This is because, similar to James, Manuel also understands his therapist’s responses as guiding him away from where he wanted to go. His space in therapy is described as being intruded upon by his therapist’s misinformed assumptions, deviating from Manuel’s own experience of being a gay teenager.

Manuel later mentions:

*“I was quite a mild mannered person ... But I don’t think she realised ... Or accepted that at all... A mild mannered person ... Like I needed somebody not threatening and somebody... Who doesn’t have huge ego... And loves the sound of their own voice...” (Manuel: 1061-1071).*

Manuel seems to emphasise that he was “a mild mannered person” as a client in therapy. This highlights his description of a rather “huge” and “threatening” therapist taking his space, possibly making Manuel feel small and helpless.

Thomas also described not having space for the exploration he wanted. When talking about his therapist’s unhelpful response to his sexual behaviour with his ex-partner he says:

*“Certainly not to tell me that he doesn’t get off on the intimacies of other people’s sex lives. Because I still don’t know what that means... But I think I would have preferred him to... Just respond by... Encouraging me to say more... Encouraging... Inviting further questions... Going on that exploration...” (Thomas: 1145-1155).*

“Certainly not” shows how outraged Thomas feels about his therapist’s response. “Because I still don’t know what that means” appears to indicate how inappropriate the response was and still is for Thomas. As a result of this response, Thomas seems to strongly feel an absence of an invitation to use the therapeutic space. His therapist’s response not only did not make sense to him but also discouraged him from exploration.

Thomas then shares:

*“But... I really wish I would have said... ‘This is what I’m left with actually’... But I think I didn’t say that because I was too afraid to... And too afraid to... I didn’t want to hurt him... I didn’t want to hurt his feelings... Because I do actually like him as a person I think... And I do, I do think that he is very caring and he supported me tremendously... So I didn’t want to hurt him in that respect...” (Thomas: 1408-1421).*

Thomas wishes he had had the space to express the impact of his therapist’s response on him. He describes being “too afraid” to hurt his therapist. Perhaps Thomas did not claim his space in therapy not only in order to protect the therapist from being hurt by him, but also to protect himself from losing an otherwise caring and supportive therapist.

#### **4.2.2.4. “You don’t get the full picture”**

All participants expressed a sense of compartmentalisation, whereby their own difficulties specifically linked to their gay identity were not allowed in the therapy room.

For example, Manuel described that his own experiences of homophobia were rejected by his therapist and not allowed in the therapy room. Instead, he felt it was more accepting to talk about how he felt regarding racist and homophobic incidents in a TV show. He said:

*“...I saw the kind of racism and homophobia connections but I’m like ‘I’m not, I’m not touching that... I’m just going to talk about how this TV show makes me feel and she believes that... I don’t know...I’m just a sensitive person’... And I’m a sensitive person... But you don’t get the full picture.” (Manuel: 460- 471).*

Manuel describes the exclusion of his own experience to result in him looking like a generally “sensitive person” rather than someone who has been experiencing the hurt of bullying, discrimination himself. Manuel seems to clarify that, even though he was still showing a real part of himself, as he is a sensitive person, he was still not feeling welcome to bring his “full picture” into therapy. “I’m not touching that” gives a sense of prohibition specifically about his experience of being gay.

Chris also felt that his sexuality was excluded from therapy. He said:

*“I used to wonder sometimes what to talk about ...Because it felt that... certain things weren’t allowed... Which is not the right place for therapy... When things aren’t allowed ...” (Chris: 405-410).*

Chris talks about his sense that certain things “weren’t allowed” to be talked about in therapy. Chris sounds as if he almost had to ‘rehearse’ specific things that he felt welcome to “talk about” in therapy. “Which is not the right place for therapy” can show that Chris is aware that this is not how therapy should work, perhaps suggesting how confusing and conflicting this compartmentalising and rejecting experience was for him.

Later in the interview Chris referred to how engaging and helpful he found his therapist for his bereavement, which contrasted with his experience of him around sexuality. He said:

*“I thought ‘Gosh you are actually doing something here... Why don’t you do that about my sexuality?’... You know... When I felt... Then I... You know, I realised after some time... Certainly when I finished with him, I thought ‘The resistance isn’t mine, about sexuality’...: ‘It’s his!’ You know, I felt it was very much his issue”. (Chris: 1064-1073).*

By saying “Gosh”, Chris seems to express how surprised he was that his therapist could “actually” be helpful. However, this feeling of surprise seems to encompass a sense of annoyance around the therapist being capable but depriving Chris of help because of his sexual identity. “I realised after some time” and “when I finished with him” suggests that it took Chris some time to realise that the exclusion of his sexuality from therapy was not his doing. This is in line with other parts of the interview where Chris appears to make sense of this compartmentalising experience as his “resistance” towards opening up to his

therapist. “Certainly” seems to illustrate how confident Chris felt once he finished therapy about the wrongness of his therapist’s stance towards Chris’s sexuality. “It’s his!” seems to echo a sense of relief and perhaps also frustration and resentment for this insight.

Similar to Chris, Thomas also described an experience of feeling like his sexual identity had to be excluded from therapy:

*“...These micro things that he would have done... Stopped me from speaking about... Sexual stuff.. I think I became quite attuned to things like his posture, his energy... Levels in the room... When he would take sips of his coffee... Or water... I don’t know if I am making this up in my head... But If I’d heard him (sigh)... Which he often did frequently in the sessions... Then I think that somehow would make me reluctant to disclose... If he changed his posture... Sat up right... In his chair or something... I think maybe that would have facilitated me disclosing what... More open...”*  
(Thomas: 1557-1590).

Thomas seems to give the sense that he had to be hyper-vigilant in therapy in order to not allow his sexual identity to enter the therapy room. Thomas describes several “micro things” that he had to be “attuned to”. This may portray the image of an exiled person trying his best to get his way back to where he was excluded from (himself as a whole) but being completely fearful of being caught and punished. “*I don’t know if I am making this up*” can suggest that Thomas is still confused about his experience of having to exclude his sexual identity out of therapy. Similar to Chris, perhaps this suggests that Thomas is wondering whether he is responsible for or imagining the fact that he could not talk about “sexual stuff” in therapy. Thomas’s description of hypervigilance can show a lack of trust and a constant fear that made him “reluctant to disclose” important parts of himself.

Unlike the other participants who spoke about their sexual and romantic experiences being excluded from therapy, Omar talked about his individual identity as a gay man and a Muslim:

*“... He started talking against religion for the rest... The rest of the session. And... I was there ...I felt... What is he going on about... I didn’t come here to hear his personal religious beliefs... You know? And a stance that was...was irrelevant to, to me... [...] Having this struggle actually...that I am gay and Muslim... and hearing my therapist...who I thought was Muslim, anyway .... Take all the space ...to talk... Against some, something... I sort of...Religion... it’s important for me ...You know...I was... raised as Muslim... And with terrorism now... And all this terrible*

*shit... people ... I feel people don't like Muslims... Making all these racist assumptions... And then I am gay... So people...people in my mosque are...you know... all the discrimination ...from them too... I certainly wanted a therapist who can understand and support me. Both as gay... and as a Muslim..." (Omar: 165-208).*

Omar describes a difficulty to have both his gay and a Muslim identity accepted and integrated in therapy. Omar seems to describe an experience of not just his space being intruded upon in his own therapy but also excluding "important" parts of his individual identity. Omar mentions that being gay and Muslim is a struggle for him. He also seems to have hoped that his therapist was Muslim too, perhaps wishing to be understood and accepted as a whole in therapy. One can get the sense that Omar feels particularly disappointed and let down from not having this hope fulfilled. Omar refers to the wider context of discriminatory assumptions against Muslims and his strong wish for "certainly" wanting a therapist who can understand him and support him with his identity as both gay and Muslim. This can suggest how lonely, helpless and misunderstood Omar perhaps felt by this compartmentalising and rejecting experience in his therapy.

#### **4.2.3. Master Theme 3: UNDERSTANDING THE IMPACT OF UNHELPFUL INCIDENTS OUTSIDE THERAPY**

All participants seemed to understand the unhelpful incidents to impact them in some way, not just in the context of therapy, but outside therapy too.

##### **4.2.3.1. "I wasn't feeling like I belonged in my skin"**

Interestingly, all six participants described a shift in how they experienced or expressed themselves outside therapy following the unhelpful incidents.

For example, Chris said:

*"... Oh that's interesting, I never thought about that... Being abused ... I felt quite abused by him... In therapy... And whether part of my... You know wearing nail varnish, being ... You know I've been quite camp for a number of years...But I'm not sure whether that's a rebellious action to how he was... [...] And I think there's a certain thing about it... So... 'I'm okay being the way I am' ... You know? I'm... I'm not an alpha male ... I'm certainly, you know, quite different as a male... I'm aware of that ... But I'm actually really happy the way I am as I am..." (Chris: 1240-1273).*



Chris repeats the word “abused”, something that might indicate how hurtful, horrible and degrading this experience has been for him. Chris’s link to a more visible “camp” or feminine expression of himself following the unhelpful experience may suggest that he experienced his therapy as oppressive. As such, perhaps the “nail varnish” is now understood as Chris freeing himself from that oppression. Chris seems to have battled with this oppression and chose to tell himself “I’m okay being the way I am” as not “an alpha male”, as “different”. One can sense Chris’s anger about this unhelpful experience and how he managed to turn it into being “happy” with how he is. However, “actually” and “really” may suggest an internal conflict regarding how “really happy” he “actually” feels following that rejecting experience.

Manuel, like Chris, describes his sense of self in empowering terms following his unhelpful therapy experience:

*“I guess it makes me quite proud... [...] Proud in the sense that like... I’m willing to kind of say I had a problem with, with a particular fear... You know... Fear of homophobia... [...] Things I noticed that, I don’t know ... You know how LGBT people are portrayed by all media and screen... Stuff like that... I would just not... Other people have talked about this to me and then I would talk...If that’s something they’d care about... On a personal level. To a professional, I would just be like... What would they know? Sometimes you just sense that you are speaking in another language [...] Um, it makes me more... Reticent, I guess.... Or more... Re-reticent... Or reserved... About sharing... (Manuel: 390-419).*

Manuel describes feeling “proud” following his unhelpful therapy experience. He seems to understand this as the result of being able to face his fear of “homophobia”. Though not clear in this quote, one can wonder whether Manuel feels particularly proud that he faced this fear independently, without the help of his therapist. Manuel describes being aware of homophobia in films and acknowledging how LGBT people are portrayed in the media. “If that’s something they’d care about” can suggest that Manuel has been more aware and sensitive of appearing “opinionated” around people, perhaps in order to avoid repeating his therapist’s unhelpful attitude towards him. Meanwhile, “on a personal level” can suggest that Manuel came to own his experiences and, unlike in therapy, felt free to talk about homophobia. Indeed, this seems to contrast with how he then describes experiencing himself with professionals as “reticent” and “reserved”. He explains this as feeling that professionals can hardly understand what he says. One can hear Manuel’s

experience of deep scepticism regarding professionals following his unhelpful experience, yet a belief in himself.

Unlike Chris and Manuel, James describes his sense of self being impacted negatively following his unhelpful experience in therapy:

*“For two weeks I didn’t leave the house... [...] I covered all the mirrors... I... couldn’t face my reflection and... I was having some weird panic attacks... I would have cold showers to calm down... And... I was telling that in therapy and yet she wasn’t... She, she... I don’t know... She wasn’t... [...] I don’t think I was able to understand anything... And... I was having some really weird feelings... I didn’t know then... When I say I didn’t trust myself, I didn’t even trust my body... I wasn’t feeling like I belonged in my skin... Um... What was I saying? Yeah... I was having nausea because I was feeling sick in my skin... And, and... Yeah she knew that... I mean was telling her, I was telling her that in therapy but she wasn’t... She, she wasn’t helping...” (James: 955-983).*

James’s experience here seems to evoke a rather dark and sad image of someone feeling deeply ashamed about themselves and expelling their existence from the world, even from the mirror. And not just one mirror, but “all mirrors”, perhaps to ensure he ceased to exist. “I didn’t trust myself, I didn’t trust my body” and “I wasn’t feeling like I belonged in my skin” can suggest a level of total disconnection from his own self and the embodied rejecting feeling towards his whole being. This disconnection can be heard here when James asks “What was I saying?”.

The negative experience James describes seems very intense and visceral. James repeats that he was “telling” his therapist about this and that “she wasn’t helping”. This may suggest that James understands his therapist to have been additionally rejecting during that phase, perpetuating his negative sense of himself outside therapy. “I don’t think I was able to understand anything” and “I didn’t know then” can indicate how very helpless and confused James understands himself to have felt then, and thus not able to make sense of what was happening to him following his unhelpful therapy experience.

Similar to James, Omar also described a negative impact on his sense of self following his unhelpful therapy experience:

*“I didn’t realise at that time, but... Thinking about it now... I think... If I was feeling not understood... and unworthy in therapy... I felt... What is the hope that... I will be understood... by other people in my life? Do you know*

*what I mean? Um... Especially after my ex... I found it hard to... to trust ... Or just, just be myself... with people... friends... dates... Anyone really... And I certainly believe this... Bad, unhelpful experience perpetuated, if not made me feel more hopeless... That I can, I can be understood, I now realise... Yeah. I was, I was too confused to notice... Also, like I said... On the other hand... I was glad I had him... At least. I didn't have anybody.” (Omar: 419-439).*

Omar's hesitancy in his speech seems to accentuate the turmoil he felt following the unhelpful experience in his therapy. Omar seems to come to a realisation that not feeling understood or worthy in therapy left him with no hope that he could feel understood or worthy with anyone else in his life. Omar seems to understand this also in the context of his bad experience with his ex-boyfriend and their break-up. Perhaps, he thinks that if the two people who saw him so closely, his therapist and his then boyfriend, rejected him, then no one would be able to accept and understand him. Omar appears to emphasise how only now he realises this impact. From what he clarifies later, it seems that at the time of the therapy he was feeling too lonely to allow himself to see the negative impact of his interaction with his therapist on his sense of self: his therapist was the only person he had and such a realisation may have made him feel even lonelier.

#### **4.2.3.2. Relationships outside therapy experienced as supportive or challenging**

All participants described experiencing their relationships outside therapy as either supportive or challenging following the unhelpful therapy incidents.

Brian, for example, said:

*“And then it really stayed with me... And then I talked about it with somebody who has ... Who has subsequently become my partner... He was in my dissertation group... He was gay... And he was like... He was really shocked by it... He said that was really terrible, that was really inappropriate...Um... So that kind of, that was part of my process, was... Confirming me and...You know, my feeling that this was not right... (Brian: 263-274).*

Brian describes how the impact of the incident followed him outside therapy. This description can indicate how overwhelmed Brian might have felt following the incident and that he had to find a safe person outside therapy to help him through it. The fact that this person later became his partner suggests how incredibly supportive Brian experienced him during this difficult time. Brian describes this person being “shocked” by the incident

and acknowledging how “really terrible” and “really” inappropriate it was. This suggests that Brian experienced empathy at a deep level with him. The use of “really” seems to emphasise Brian’s sense of being validated.

Similarly, Chris described a sense of support from colleagues:

*“I had a number of therapists that I could talk to.... I would bring it up about the course... You know, I might even bring it up in supervision with.... You know, um... If I was there early and ...The other supervisee was early, I’d... Bring it up and talk to them about it... It’s just (sigh)... It wasn’t possible to...to work through it in therapy ....” (Chris: 949-970).*

Chris describes the unhelpful experiences not being “worked through” in therapy and Chris being left with the need to seek help elsewhere. It seems that people from his course and supervision provided him with that support. It seems that other people in his life made “possible” what was not possible through therapy: a safe space to talk and feel supported.

Unlike Chris and Brian, James described relationships outside therapy as challenging following his unhelpful experience of therapy:

*“... I wasn’t able to let people in.... I was always shutting people down... I was always pushing people away... [...] I wasn’t able to open myself to other people... And I kept doing that for, for some time... Not with friends but in terms of relationships with guys... [...] I wasn’t realising at that time... And every time a guy would show some, some interest in me... I would just freak out... And it was too much, I couldn’t handle it... Even human contact... I mean even just touching... [...] I hated it when someone came too close to me... And I hated it when someone invaded my space...” (James: 1205-1225).*

James mentions “shutting people down”, pushing them away, and not opening himself to them. These relational processes outside therapy seem to strongly parallel what James described feeling during the unhelpful incidents in his therapy. He then describes how these processes were relevant specifically for his intimate relationships. “I would just freak out” can vividly portray how very scared, suspicious and even repulsed he would feel in intimacy with others. James mentions that he did not realise these processes during the time of the therapy. This can show how very confusing it was for him then.

Similar to James, Thomas also described a “parallel” difficulty when relating to others intimately:

*“(Sigh)... Um... Yeah, I think where it impacts my interpersonal relationships is in ... Romantic or sexual relationships... There are things that I just can’t talk about... So it mirrors... There’s a parallel process... And I wanted.... Maybe I didn’t know at that time... But I think I really wanted to be able to talk about things with a therapist that I would want to have conversations about with, with... With a partner... But I wasn’t able to do that... And I think that... That would still be the case... So... The relationship that I am currently in, I feel like there are the same patterns being repeated... With an avoidance of intimacy of sexual stuff or sex... It’s not something that I can’t talk to.... I cannot talk about it... And ... Yeah... So I feel like a bit of a parallel process... [...] Frustrated... Frustrating... And fear and those sorts of shame emotions...” (Thomas: 1499-1538).*

Thomas sighing gives the sense that he still feels troubled. Unlike James, Thomas describes that this parallel challenging interpersonal process seems to still be relevant. He seems to emphasise how this process “mirrors” what was happening between him and his therapist. Thomas appears to understand that the conversations he hoped to have with his therapist were conversations he wanted to have with a partner. Thomas may thus feel that his current relational challenges remain a difficulty because of how rejecting his therapy experience was. Thomas describes how he still finds it difficult to talk about intimacy and sex to his current partner. He repeats that he “can’t talk” about it, which may emphasise how strongly “frustrated” he feels with this relational “parallel process” and associated difficult feelings of fear and shame that remain an issue for him up to this date.

#### **4.2.3.3. Finding a way forward**

Finally, all six participants described how they found their own way forward from this unhelpful therapy experience that impacted their lives outside therapy as well.

For example, Brian spoke about seeking another therapist:

*“I needed to go back to some... You know, long-term therapy... So, actually that... When I returned to London... And then I did, you know, eventually start looking for a gay therapist... And then I saw him for a few years... And actually, you know... We did very good work. But it was, you know... I had to see... I’d really needed to see a really good therapist... So I had to see a gay therapist.... And feel fully... You know, supported...” (Brian: 926-940).*

Brian mentions seeking long-term therapy in London, a place he had previously described as more accepting than the North of England where his unhelpful therapy experience was.

He also specifies “looking for a gay therapist”. Brian describes needing to “go back” to a supportive place of acceptance.

This description may indicate how the unhelpful incident gave Brian a clearer sense of what he did want from therapy. Brian seems to confirm this to himself by saying “actually” and “we did very good work”, when speaking of his subsequent therapy. The “we” in this phrase seems to suggest that Brian felt equal and not discriminated against in his subsequent therapy experience. With “really needed to see” and “a really good therapist” Brian seems to emphasise the real urgency of wanting and also managing to find a therapeutic space where he finally felt “supported”.

Omar also described managing to move forward from the unhelpful experience:

*“Regardless of the shit that comes to my life... I always take the positives... [...] I came to...I like to choose the people close to me... And after that especially ...I think I became even more selective to... As to who I choose to be, to have next to me as a friend, you know? So ...I took the good things from there and I must say... I was very lucky to meet some good, good friends in the lab later, where I work now... And yeah... I can, sort of, I can feel understood now.” (Omar: 503-523).*

Omar explains that he always takes the positives from whatever happens to him. He sees this outlook as having helped him move forward from the unhelpful therapy experience. Omar mentions that the therapy helped him to become more selective about his friends. Similar to Brian, Omar seems to feel that this negative experience made him more aware of what is “good” for him and made him seek it. The repetition of “good” can suggest that Omar came in touch with what “good” he was missing following his unhelpful experience in therapy. Accordingly, Omar moved forward towards pursuing this “good” by finding friends with whom he could “feel understood”.

Similar to Omar, James described moving forward from an unhelpful therapy experience:

*“As I was getting better I was having doubt about her... [...] I mean in a way it's good... Because it made me realise that I've made the work myself for myself... And she was just a tool that I used to get to that part... [...] And that's a good feeling... But during the whole pro... The whole therapy... The whole process... It wasn't, it wasn't the purpose...” (James: 719-830).*

James described how, regardless of the unhelpful incidents, some aspects of his therapy helped him feel better. Feeling better meant that he was able to realise that this therapy was not exactly what he wanted. James seems to come to an understanding that what

was good for him in therapy was his own work. James seems empowered by this understanding as he says “in a way it’s good” and “that’s a good feeling”. However he realises that this was not the “purpose” of therapy. James’s description of his therapist as a “tool” might suggest that he has come to see this experience in a constructive way. However, a tool is an object and not a human. Thus, “tool” can also imply how inhumane this “whole process” of therapy was for James.

Manuel described finding his way forward in different ways, including sharing his experience in this study:

*“I know I’m angry that this happened... But I know what went wrong ... I know... That it’s not, you know, that it’s her problem... That it’s her fault, not mine... And so... I just know that I am right... [...] It shouldn’t have happened, but it did. So... I would want people to know about it... From this study [...]... When I was at university the first time, I volunteered for my university’s night line... And they trained us a little bit on gender identity and sexuality... [...] ...I think talking about that and being told about it... And being around people who cared about it ... Did help. [...] So that’s what I would suggest. It’s being with people who have... Who understand it a bit more... Or... You know... And... Yeah, to get information about it yourself and how to support people...” (Manuel: 823-886).*

Manuel expresses that he is still angry about his unhelpful experience in therapy. He describes being aware of what went wrong in therapy and he seems to understand that these incidents should not have happened. This seems to make Manuel feel validated as he says, “I just know that I am right”. It seems that Manuel holds the hope that, by sharing his experience for this study, such unhelpful therapy incidents will not happen as much. It could also mean that Manuel hopes that at least someone else, who will read this study, might also feel angry with what has happened and Manuel will have his feelings understood and validated.

Manuel then goes on to share that what helped him to move forward in his life following the unhelpful therapy experience is his volunteering at his university. This is when he had the opportunity to be trained about matters like gender identity and sexuality. Though he does not say it explicitly, it could be implied that Manuel might feel that, unlike his therapy experience, the knowledge and awareness he gained from his training was useful and made him feel supported. Manuel seems to suggest that what actually helped him was talking about gender identity and sexuality with people he felt understood and cared about his situation. This seems to resemble the experience of Brian who went on to find support

from a therapist who seemed more aware and supportive in relation to sexuality matters, and could thus resonate with his own experience.

Finally, Manuel suggests that surrounding yourself with people who understand sexuality a bit more and seeking information about these matters yourself can be helpful. “Being with people” may show that Manuel feels that he has managed to move forward from the vulnerable and lonely stage he described previously. However, “get information about it yourself” might indicate that Manuel still does not fully trust professionals around sexuality. Perhaps his “and how to support people” implies a wish to move forward from that by urging all professionals who read this study to gain the essential knowledge that will make them trustworthy in supporting gay men.



## **5. Chapter Four: Discussion**

This research aimed to investigate how SIGM in the UK experience and make sense of unhelpful incidents in therapy, assuming that these incidents were linked to their sexual orientation. Using IPA, the analysis strived to capture the lived experience of the participants and sought an interpretative understanding grounded in their descriptions. In line with the principles of IPA, during the process of the analysis I endeavoured to 'bracket' my engagement with the relevant literature in order to ensure that my interpretation was generated from the data.

In the Synthesis of Findings section below I draw directly from the data and present three overarching themes or "key take home messages" that emerged from the analysis. This can help the reader see what could be learnt from this empirical research.

In the Discussion of Themes section I discuss each subtheme in relation to existing psychological literature. A critical discussion then follows. I conclude with some suggestions for the training, clinical and research implications of this study.

### **5.1. Synthesis of Findings**

#### **5.1.1. *The experience of a dismissive, stereotyping and unempathic therapist.***

As mentioned in Table 1 and explored throughout the Analysis chapter, each participant described a different incident as unhelpful in their therapy. Yet, all of these incidents made the participants feel diminished, dismissed, stereotyped and rejected. Consequently, the participants were left feeling that they cannot be understood.

Brian understood his therapist's unhelpful self-disclosure as the therapist's lack of "*any diversity training*". Still, following this incident he thought that "*there is something to reject*" about himself and that this experience tapped "*into very early feelings of low worth [...] being worthy of rejection*". It "*inhibited*" him and prevented him from being open as a gay man. He said that feeling rejected by his therapist was "*just like a closing down*" for him.

Moreover, Chris described how his therapist "*didn't give a damn*" about him and how therapy "*felt very corporatized... [...]There wasn't any human interest in it*", specifically regarding topics around his sexual orientation. As a result, Chris "*didn't feel respected at all*". Rather, he "*felt judged ...And disavowed*" by his therapist.

Manuel described a dismissive therapist who was sticking "*to her own kind of privilege*". Consequently, this appeared to perpetuate his fear of "*being seen as a token or stereotyped*". Consequently, Manuel expressed fearing that no heterosexual professional would understand him as a gay man. He thought: "*what would they know? Sometimes you just sense that you are speaking in another language*".

Similarly, Omar's therapist dismissed what would be most helpful for him to hear in order to feel understood and affirmed for his own gay identity. This deprived Omar of an opportunity to *"feel confident that it's okay to be gay"*. He was left feeling *"unworthy in therapy"* and started losing hope that he will ever be understood as both a gay and a Muslim man by others. The experience of a dismissive and stereotyping therapist was so deeply disconnecting that James isolated himself from the world and covered all the mirrors so he could not see himself. He said: *"I didn't trust myself, I didn't even trust my body. I wasn't feeling like I belonged in my skin"*.

#### **5.1.2. The discriminatory practice affected clients harmfully on an intrapersonal and interpersonal level.**

Another noteworthy finding evident in all three Master Themes is the intrapersonal and interpersonal harmfulness of the unhelpful therapy incidents. Such a harmful effect encompassed feeling vulnerable, a sense of shame and not being able to trust others. This finding is particularly worth noting because of the fact that, even though harmful, these experiences seemingly remained unidentified by the therapists and the clients kept attending their sessions for some time.

For example, Omar's unhelpful experience of therapy left him feeling "alone" and thinking that he *"wasn't worth it"*. Yet he wanted to *"to keep going to hopefully feel better"*. Chris described how his therapy *"was quite a horrible experience"*. Yet he kept going, though he noted: *"colleagues of mine used to say 'Why you keep seeing him?'"*. Interestingly, both Omar and Chris understood the experience of discrimination in therapy to be their fault, because they were not worthy or because they were "resistant". Brian also kept attending therapy after the unhelpful incident, even though he described it as taking him back to *"thinking that actually there is something to reject"* and giving him *"feelings of low worth and shame"*. James said: *"I was feeling sick in my skin"*, describing a somatised experience of this shame. Thomas mentioned *"feeling quite afraid"* of his therapist. He described feeling: *"fear of judgment [...] feeling afraid that my shame, my internal shame would come out and be exposed or that I would be left feeling very exposed and humiliated"*. These words illustrate how very vulnerable and ashamed Thomas felt following his unhelpful therapy incident.

This harmful effect of the unhelpful therapy experiences followed the participants in their interactions outside therapy as well. For example, Manuel described how as a result of his therapy he was left not feeling comfortable to talk to any professional about matters in relation to his sexual orientation. Other participants described the impact of their unhelpful therapy on their intimate relationships. For example, Thomas said: *"I really wanted to be*

*able to talk about things with a therapist that I would want to have conversations about with a partner*". However, he clarified that he was not able to do that in therapy and as a result this remained an issue for him. Similarly, following his unhelpful therapy experience, James said: *"I wasn't able to let people in... I was always shutting people down... I was always pushing people away"*. These accounts illuminate the interpersonal damage that discriminatory experiences in therapy had on these participants, perhaps because their therapist was unable to identify this harmful impact and work it through with them.

### **5.1.3. The importance of social support for SIGM clients**

One can hear the sense of loneliness and the unfulfilled need to feel connected with another human being across the different Master Themes of this research. The participants described feeling lonely and lacking social support before starting therapy. Their hope to feel connected with another human being, however, was instead met with a sense of disconnection, betrayal and rejection because of the harmful impact of the unhelpful incidents. An interesting finding of this study is that most participants managed to nonetheless move forward through finding social support.

We hear James's need for someone to support him, whilst he was not in touch with his family: "I mean I wasn't in touch with my mom and no one in my family. I needed... [...] So I went to see that therapist and I think I needed I, I, I really needed help". At another point, talking about his therapist, James said: "She was the only person I could trust around me... I didn't have... I had nothing... I had no money, I had no family support". Brian, in fact tried to reconnect with his family during a difficult time of his studies. He described his family, however, as lacking understanding about sexual minority matters. Brian seemed to hope for this deeper understanding and support through therapy: "So I needed some therapeutic support ... Just to get me through that..." Manuel described feeling socially isolated during the time he started coming to terms with his sexuality. He described this phase as "... something I really, really wanted to, to talk about... [...] ... Because, I was quite lonely... I was quite a lonely teenage." Omar also gave a picture of someone hoping for social support, acceptance and understanding for whatever he was: "I wanted someone to understand me and, and support me...with whoever.....whatever I am, I believe". Earlier on in his interview Omar said "I wanted my therapist to be able to understand me. So... I have asked if it was possible to have someone who is gay". Omar's deep need for acceptance and social understanding can be heard later when he says: "I felt... I was like an alien... another... From another planet." This seemed also the case for Thomas, who was hoping that a gay therapist would give him appropriate and non-judgmental support at a time that he was feeling "very, very incredibly lonely."

Hoping for connection with his therapist, Chris said: “just be a human being”, and this is what all participants seemed to want to connect to, just a human being. Nonetheless, talking about the unhelpful therapy incident Chris said: “There wasn’t any human interest in it ”. Similarly, Brian wondered: “does this relate to the fact that it’s not being very relational [...] It’s not really being very connective”.

So strong was the need for social support that some participants seemed to take full responsibility for the unhelpfulness of their therapy themselves. “Well, I wondered if it’s a resistance...I wanted to try to work through the resistance [...] Is it my resistance?”, Chris wondered. “I wanted to...to keep going back to...to see...to feel better”, Omar said.

Most participants described moving on from these unhelpful experiences through supportive human relationships. Omar made some “good friends” from the lab and felt “understood”. Brian felt “fully supported” through a gay therapist. Even though Manuel found it difficult to trust other professionals, similar to Omar, he expressed benefiting from his peers. Manuel said that “being around people who cared about it ... did help”.

Despite the participants noting how they moved on in some ways, however, the negative impact of the unhelpful therapy experiences is clearly demonstrated in the accounts of all participants. Moreover, what all participants seemed to also express is how strongly the absence or existence of a sense of social support impacted their experiences as SIGM in and out of therapy.

## **5.2. Discussion of Themes:**

### **5.2.1. Master Theme 1: MAKING SENSE OF DISCONNECTION**

#### **5.2.1.1. *“I was quite lonely”***

Participants’ descriptions revealed that they had been feeling vulnerable and lonely prior to therapy. They shared longings for a therapeutic bond that could offer them the acceptance and support that they were missing.

There is no previous research exploring the feelings of gay men or sexual minorities upon starting therapy. However, the participants’ vulnerability and hope to be understood upon starting therapy was also supported by Milton’s (1999) study with lesbian and gay male clients. The present study adds to that by illuminating different experiential manifestations of the need of SIGM clients to be offered an accepting therapeutic relationship where they can “finally feel understood” (Omar).

This finding is consistent with research exploring gay men’s feelings of loneliness in the context of living in a heteronormative society (Martin & Knox, 1997; Chaney, 2008;

Kuyper & Fokkema, 2010). Heinrich and Gullone (2006) described loneliness as an emotionally unpleasant experience where one perceives their personal relationships to be somewhat inadequate. Indeed, all participants described going through “a very difficult” (Brian, James) time before starting therapy and needing someone to understand and help them. Loneliness can be influenced by perceived social acceptance (Asher & Paquette, 2003) and this is also reflected in the accounts of all participants, particularly Manuel who mentions being a “quite lonely teenager” trying to come to terms with his sexual minority identity at school.

Mearns and Cooper (2018) in *Working at Relational Depth in Counselling and Psychotherapy* have elaborated on how anxiety and depression are often the result of the lack of close relationships. As such, they have emphasised the importance of experiencing a relationally deep encounter in therapy. Like Mearns and Thorne (2000) stated, “for the client whose history of relationships has been disturbed and whose self-acceptance is weak, such intimacy may be a unique experience and is therefore powerfully instrumental in the development of his self-regard” (p.144-145). Someone starting therapy might additionally feel vulnerable because of having made several efforts to overcome their difficulties with no success (Frank & Frank, 1991). When we refer to gay clients like the participants of the present study, these assumptions could be fortified by the experience of *minority stress* (Meyer, 2003).

Sexual minority clients come to therapy with the prolonged experience of stigma and discrimination from heterosexist social environments (Bruce, Harper, & Bauermeister, 2015; Meyer, 2003). Social theorists argue that such a social context can make individuals more vulnerable to stress and alienation (Allport, 1954; Goffman, 1963; Link & Phelan, 2001). Indeed, Olesen, Campbell and Gross (2017) discuss how distress amongst sexual minorities is often predicted by social isolation and feelings of shame linked to the experience of discrimination, even from one’s own family. Indeed, in his interview Brian mentioned how starting his therapy was important at a time when he moved back with his family, a family that was described to lack awareness regarding sexual minorities.

Not all participants described feeling lonely or vulnerable because of difficulties linked to their sexual orientation upon starting therapy. However, it could be relevant that the microaggressions (Shelton & Delgado-Romero, 2011) and discrimination (Meyer, 2003), alongside the lack of social support (Lackner, Joseph, Ostrow, & Eshelman, 1993) the participants in this study might have experienced as gay men in their lifetime, might have added to their experience of feeling lonely and unsupported. Even if gay men accept the

dominant heterosexual culture that surrounds them, they may still feel '... outside the mainstream' (Lewis, Derlega, Berndt, Morris, & Rose, 2001, p. 64) and a need for a sense of belonging (Nel et al., 2007).

Still, James stated financial and family difficulties not related to his sexual orientation to be an issue for him upon starting therapy. James's description mirrors Sorensen and Roberts' (1997) findings indicating depression and financial and family difficulties to be the main problems clients experience upon starting therapy. Nonetheless, this study included only participants identifying as lesbians. Furthermore, a study by Israel et al. (2008) indicated that only a small percentage (16.7%) of their participants reported their difficulties to be linked to their sexual identity upon starting their therapy. However, this study did not exclusively focus on the unhelpful experiences perceived to be linked to one's sexual orientation.

#### **5.2.1.2. "Just be a human being"**

As also seen above, the participants' expressed sense of loneliness was accompanied by a deep hope to feel understood by and connected to another human. Bowlby (1988) claimed that "the therapist's role is analogous to that of a mother who provides her child with a secure base from which to explore the world" (p. 140). This quote seems to resonate with what the participants were longing for, a secure base to be themselves and make sense of their various difficulties in the presence of a supportive and understanding therapist.

This finding supports Mearns and Cooper's (2018) concept of psychological distress as often the result of a lack of close interpersonal connections. Consistently, existing literature states that gay male clients might feel particularly isolated and longing for a human connection with their therapist because of lack of social connections and support (Kronner, 2005). Considering the various levels of *relational trauma* (West, 2016) as a result of discriminatory responses and social stigma, the experience of a supportive and accepting human connection could be vital for gay men (King et al., 2007). Balick (2010) explains that the therapeutic encounter "has the capacity to echo the feelings of rupture that may have been key components of previous relationships" (p. 47) of gay men, and a human connection is what the participants appeared to hope for in therapy.

Similarly, Milton's (1999) gay and lesbian participants described the relationship with their therapist as significant to them. Milton related their accounts to the literature (e.g., Clarkson, 1995; Spinelli, 1994; Winnicott, 1977) that supports the relationship between the client and therapist as crucial in the process of therapy. Moreover, Pixton's (2003) lesbian and gay participants described the sense of connection they had with their gay-affirmative therapist as helping them feel comfortable, understood, supported and

validated. LGBT participants in research by Israel et al. (2008) also reported the importance of a caring, warm, respectful and trustworthy therapeutic relationship. These findings came from studies that did not focus on the experiences of just gay men in therapy. Lebolt (1999), however interviewing only gay men, also found that participants emphasised the importance of human connection with therapists who can understand and accept them.

Sexual minority individuals, like the gay men participating in the present study, may experience prejudice and discrimination from parents (Rivers, 2002; Salzburg, 2004), at school (Huebner, Rebhook, & Kegeles, 2004), at work (Chung, 2001) and in the broader society because of their stigmatised status (Denton, Rostosky, & Danner, 2014). Not all participants in this study reported experiencing homophobia from their families (e.g., James), supporting research that some families can be accepting and supportive towards their gay sons (Ben-Ari, 1995; Gorman-Murray, 2008). However, as Davies (1996a) stresses, exposure to homophobic messages is inevitable for all sexual minorities to some extent. Therefore, all participants of this study might have begun therapy following numerous experiences of being deprived of human connections in which they were accepted and embraced as gay men.

Though the participants of this study had therapies of different modalities, they expressed longing to feel “understood” (Omar) “consistently” (Thomas) by someone with whom they can feel “trust” (James), and who is a “human being” (Chris). Indeed the book *Therapeutic Perspectives on Working with Lesbian, Gay and Bisexual Clients* (Davies & Neal, 2000), mentions the importance of an accepting therapeutic relationship across all modalities. Such a description of a therapeutic relationship is also highlighted by Henkelman and Paulson (2006) as beneficial across different therapeutic modalities with all client populations. Various researchers (Wampold, 2001; Clarkin & Levy, 2004; Norcross, 2002) agree that common elements in all therapies that are linked to better therapeutic outcomes include a therapeutic relationship where the client can feel safe and emotionally contained. Traditionally, the client’s connection with the therapist has been emphasised as an important component in therapy by the humanistic (Mearns & Cooper, 2018; Angus, Watson, Elliott, Schneider, & Timulak, 2015) and psychoanalytic (Martin, Garske, & Davis, 2000; Miller-Bottome, Safran, Talia, & Muran, 2018) approaches, and also more recently by Cognitive Behavioural approaches (Dattilio & Hanna, 2012; Wilmots, Midgley, Thackeray, Reynolds, & Loades, 2019).

The participants of this study appeared to hope for a human connection that, as described by Mearns and Cooper (2005), would help them “move beyond their feeling of being

totally alone, towards a sense that at least one other person knows who they are” (p. 48), giving them a sense of belonging to the wider matrix of humanity. As Pixton (2003) showed with her research, such a connection can be possible if sexual minority clients perceive their therapist to be understanding of issues affecting sexual minorities and to be comfortable with them identifying as gay. As will be discussed below, the accounts of the participants in the present research revealed that the lack of such a supportive therapeutic relationship could make them feel further alone and disintegrated.

#### **5.2.1.3. *“It’s not really being very connective”***

All participants described their unhelpful incidents in therapy to be marked by an experience of disconnection with their therapist and the therapeutic process altogether. This contrasted with their hope for a human connection. Participants perceived a distant and rejecting therapist who was not comfortable with their sexual identity.

Such a relational disconnection resembles what is mentioned in the literature as a “rupture” or, in Kohut’s terms, “empathic failure” (Safran, 1993). Findings by Rhodes, Hill, Thompson and Elliott (1994) suggest that to resolve incidents of relational disconnection there needs to be a sufficient quality of relationship already, and an ability to discuss negative feelings with a therapist who is able to accept and willing to work through them with the client. However, all participants described the contrary. For example, Thomas said “...I could not talk to him”, even “feeling quite afraid” and ultimately deciding to end his therapy.

Some research shows that, if the client perceives the therapist to have a good understanding of diversity, this can lead to a positive therapeutic relationship (Owen, Tao, Leach, & Rodolfa, 2011b; Asnaani & Hofmann, 2012). Constantine (2007) found that the experience of cultural microaggressions in therapy is linked to decreased therapeutic connection. Nonetheless, Owen, Imel, Tao, Wampold, Smith and Rodolfa (2011a) found the cultural experiences of microaggressions to be consistently mediated by the client’s perception of an already established strong therapeutic connection. These studies refer to cultural diversity and not to sexual minorities in therapy. They are, however, consistent with the accounts of the participants of this study, describing how a sense of rejection of their gay identity impacted their relationship with their therapist.

Ackerman and Hilsenroth (2001, 2003) also addressed the relationship between the therapist’s criticism and relational disconnection in therapy. Additionally, Grafanaki and McLeod’s (1999) participants reported as highly helpful the incidents where they perceived their therapists to be understanding and validating. Their participants described sharing deep and often shameful experiences with their therapist. They found helpful how the therapist would defuse the shame and stay connected to their process. In the present study, Thomas



described “feeling very exposed” and “humiliated”. His profound feeling of “shame” and also James’s experience of “feeling insulted” and “shocked” can give an even stronger tone to how a client can experience disconnection with their therapist.

Mollon (2002) explains that as humans we are social beings wanting to be valued, approved and recognised. However, shame comprises feeling defective, inadequate, unlovable and unacceptable. Mollon states “ ...shame is about a broken connection between one human being and others - a breach in the understanding, expectation, and acceptance that is necessary for being a valued member of the human family” (p.142). This description of shame mirrors the disconnecting experience of the participants of this study with their therapists. This experience could have been deeply difficult for them and indeed insulting or shameful, considering the pre-existing experiences of feeling defective, inadequate, unacceptable and unlovable they potentially had as gay men in heteronormative communities (Davies, 1998; Meyer, 2003).

Similar to the finding of this study, Mair’s (2003) gay male participants described feeling disconnected from their therapists when they sensed them to miss the significance of gay-related issues/experiences. Moreover, participants in the study by Israel et al. (2008) identified as unhelpful their experiences of their therapists as disengaged, not caring, cold and distant. They described such experiences as making them feel dissatisfied, rejected, betrayed, frustrated and hopeless. Consequently, the connection with their therapists was impacted negatively, sometimes resulting in clients terminating therapy, similar to James and Thomas in the present research. Conversely, Lebolt’s (1999) and Pixton’s (2003) participants described warm and supportive connections with their therapists. Interestingly, they mentioned their therapists’ affirmative stance, such as their awareness and knowledge around sexual minority matters, to be helpful in this process of connecting. These affirmative aspects of a helpful therapeutic relationship were also identified by LGBT participants in the study by Israel et al. (2008).

Mair (2003) highlighted the possibility of his participants’ own internalised homophobia being projected onto such unhelpful therapists’ responses. This is a possibility to consider when trying to understand clients’ experiences of unhelpful incidents in therapy. However, the IPA lens of the present study attempts to enrich the current understanding of how clients experience and make sense (Smith et al., 2009) of such incidents in therapy, rather than focusing on the client’s *reality testing* (Freud, 1985).

#### **5.2.1.4. “Keep going to hopefully feel better”**

The abovementioned rejecting and disconnecting experience evoked some difficult feelings in the participants, such as anger, shame and confusion. Yet, they described how they kept going back to see their therapists.

Brian mentioned his unhelpful experience of therapy bringing back earlier feelings of “being worthy of rejection” from others and reminding him of “feelings of low worth” and “shame”. This can support the notion that prior experiences and different contexts may shape one’s embodied subjective experience and relationship to the world (Eatough & Smith, 2008; Smith et al., 2009). Yet Brian seemed determined to stay in therapy with a hope to work these difficult experience through. Omar also mentioned feeling “alone” and “keep going back [...] to feel better”. This is consistent with findings from Bowie, McLeod and McLeod’s (2016) study that focused on the general population. Their participants stayed in therapy regardless of unhelpful experiences, hoping that it would get better. Safran (1993) discussed how the resolution of a therapeutic relationship rupture can offer a ‘corrective emotional experience’ for clients who had experienced deep rejection in the past. Perhaps the participants of this study were perceiving therapy as their last hope to be fully accepted with their unique gay identity by another.

Chris described wondering if the unhelpful experience he had with his therapist was the consequence of his “resistance”. Psychoanalytic literature often describes the client’s resistance to result in ruptures in therapy (e.g., Safran, 1993; Bordin, 1994). Traditionally, CBT explains the client’s disengagement with their therapist/therapy as the result of the client’s avoidance and distorted thinking (Beck et al., 1979). Contemporary CBT, however, takes into account the therapist’s role too (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008). Humanistic and Experiential approaches see ruptures as accurate representations of what is happening in the here-and-now between the client and the therapist (Watson & Greenberg, 2000). In fact a meta-analysis by Del Re, Horvath, Flückiger, Symonds and Wampold (2012) showed that the therapist might make a larger contribution than the client in the alliance. The findings of the present research can add to the literature above by showing certain therapist responses may re-traumatise and disconnect the clients from the therapeutic process, though clients might still attend their therapy sessions.

Researchers agree that it can be difficult for clients to express their dissatisfaction to their therapists (Levitt, 2002; Sells, Smith, & Moon, 1996), and sometimes blaming themselves for it (Dale, Allen, & Measor, 1998; Lietaer, 1992) can be a way to cope with this difficulty. This could explain further Chris’ and Omar’s feelings of responsibility about the sense of

disconnection with their therapists. It is consistent also with James describing how he “should have been angry” with his therapist but found it difficult to get in touch with this feeling. Such phenomena in therapy are considered harmful for clients and can be understood as the result of the destructive use of power dynamics put in place by therapists (Armsworth, 1990; Bates, 2006; Dale et al., 1998).

Shelton and Delgado-Romero (2011) illuminated how clients may be left feeling doubtful about their therapy and their therapists’ investment in it when their experience around their sexual identity is minimised. They also showed that some participants felt forced to comply with therapy. Similarly, most participants in the present research expressed a sense of confusion following their rejecting and invalidating experiences in therapy. It is possible that this confusion made it unclear to them whether they should address the unhelpful experience in therapy. Literature agrees that the experience of invalidation can stop people from addressing the issue, as they might feel confused about their interpretation of it (Hodson, Dovidio, & Gaertner, 2010).

Some evidence could suggest that the participants of the present study kept going back to therapy and did not acknowledge their experiences of the rupture because they wanted to protect the relationship with their therapists from negative emotions (Rennie, 1994). This could show the extent to which the participants wanted a strong therapeutic relationship, something also evident in several studies on clients who have been marginalized in the past (e.g., Asnaani & Hofmann, 2012; Davis & Ancis, 2012; Lee, 2012; Smith, Rodríguez, & Bernal, 2011).

## **5.2.2. Master Theme 2: A REJECTING THERAPY FOR A GAY INDIVIDUAL**

### **5.2.2.1. ‘Gay-blind’ therapy practice**

Participants perceived their therapist as someone who was not willing to validate their own experience of being gay. This would have left them thinking that their therapist was not listening to them, and feeling judged when talking about their sexual identity in therapy. Consequently, they felt dismissed and angry. My ‘gay-blind therapy practice’ term is similar to what Sue, Bucceri, Lin, Nadal and Torino (2007) discussed as “colour-blind” attitudes and attempts to capture how the participants experienced their therapists’ responses. As Shelton and Delgado-Romero (2011) elaborated, “colour-blind” attitudes can give rise to responses or microaggressions that are experienced as stereotypical and dismissive.

Like the participants of the present study, many of Mair and Izzard’s (2001) participants described feeling “unseen” and frustrated as their therapist did not help them feel safe to

explore their sexual identity. Even when participants did not feel that their difficulties in therapy were linked to their gay identity, being acknowledged and heard as gay men was still considered as important. As Dickey (1997) stated “...it *does* matter if the client is...gay; homosexuality is *not* the same as heterosexuality. ...the counsellor...needs themselves to be aware of what the client might have experienced in a largely homophobic world and how this might have been internalised and what strategies they might have developed to deal with it” (p.10).

Some research indicates that gay clients prefer gay therapists (Goldblum, Pflum, Skinta, & Balsam, 2017). Like Omar, participants in Quiñones, Woodward and Pantalone’s (2017) study also mentioned as important that their therapists identified as gay. Kooden (1994) postulated that a gay male therapist could function as a role model and engage in community activism by self-disclosing his sexual orientation. This could be why Omar described how unhelpful it was for his confidence to experience his therapist as “hiding his gay identity”. Milton’s (1999) study indicated how such experiences might perpetuate the client’s fears and negative views around their gay identity. Guthrie (2006) mentioned that therapists hiding their sexual orientation could evoke shame in the client or imply that sexual orientations should not be talked about. Similarly, Isay (1991/1995) argued that the therapist’s comfort or discomfort with their own orientation can communicate acceptance or shame.

However, even though Thomas hoped that having a gay therapist “would have somehow made it easier” for him, he then felt “a bit disillusioned with therapy” having experienced some judgemental responses around the expression of his sexual orientation. Similarly, Mair (2003) illuminated how gay therapist can be invalidating to their gay client’s own experience of being gay. Moreover, some participants in the Goettsche (2015) study described having a heterosexual therapist as helpful. It appeared that having a member of the dominant culture as an accepting therapist could provide them with a new corrective experience compared to the societal and familial rejection these clients had experienced. As Ryan (1998) clarifies, regardless of their sexual orientation, therapists will represent society to clients and this can only be helpful if the therapist is not actually homophobic.

Unlike the participants of the present study, Pixton’s (2003) participants described the therapist’s awareness about sexual minority matters to be affirming and helpful for the therapeutic relationship. As such, the therapist was experienced as “non-judgmental”, “validating” and “reassuring”. Similar experiences in Lebolt’s (1999) study helped participants feel accepted and thus complete human beings in therapy. Some of the

participants in the study of Quiñones et al. (2017) also found it helpful when their therapists openly listened to and validated their lived experience and individual meaning of being a sexual minority on both personal and social levels. This helped them develop their sexual identity and decrease their feeling of shame and internalized homophobia.

Golding (1997) highlighted that sexual minority communities are not homogeneous. Consistently, the participants of this study described wanting to be validated as unique gay individuals by their therapists. The unhelpful experiences described by these participants seem to support Spinelli's (1994) claim that "the therapist must be willing to set aside theoretically based assumptions, biases and generalisations about human experience so that the client can be viewed as a unique being who generates distinctive, singularly applicable meanings and world views..." (p.257).

Here, and in all subthemes of the 'A rejecting therapy for a gay individual' Master Theme discussed below, one can see how Langdridge's (2014) idea of a gay affirmative therapist focusing on the client's phenomenology, embodying empathy and encouraging a deep exploration of the client's own meanings of their sexual identity could be experienced as helpful. Langdridge (2014) also emphasised the importance of therapists having sufficient knowledge, awareness and sensitivity about sexual minority matters prior to working with clients from LGBTQ communities. Perhaps, that is why recent studies (e.g. King & McKeown, 2004) are more likely to report that clients have 'gay-affirmative' experiences than older studies (e.g., Gambrill, Stein, & Brown, 1984). The findings of the present study suggest, however, that such unhelpful experiences of discrimination can still occur in therapy. This can highlight the need for more awareness and sensitivity in this area.

#### **5.2.2.2. *"It is not okay to talk about this stuff"***

The descriptions of the participants indicated that the unhelpful incidents in therapy gave them an experience of rejection and sometimes confusion and shock. Consequently, this made them feel unsafe to talk about matters linked to their sexual orientation. The participants felt "inhibited" (Brian), and that there was "no point" (Chris) in talking. Manuel experienced his therapist as not able to "stand to listen" and Thomas described not being able to open up because of sensing a "barrier". The participants' use of language can illustrate how they constructed their experiences as sharply silencing (Eatough & Smith, 2008). Participants also mentioned feeling that "it is not okay to talk about this stuff" (Thomas), referring to stuff linked to their gay identity, and feeling "very judged about being gay" (Chris). One can hear the shame the participants appeared to

feel with their therapists. Indeed, “shame is a powerful inhibitor of honest emotional communication” (Mollon, 2002, p.140).

The participants in this study described not being able to talk about their gay identity even in their own therapy. Manuel described not feeling comfortable opening up to any professional following his unhelpful experience. Though the disclosure of sexual orientation to important others can help the development of a positive gay identity and psychological well-being (Peterson, 1996; Pachankis & Goldfried, 2004), research shows that realistic fears of secrecy makes that disclosure difficult (Goldfried, 2001). Nel et al. (2007) discussed how sexual minorities keeping their sexual orientation a secret can experience anxiety, guilt and feelings of low self-worth. Furthermore, people having to conceal their sexual orientation may feel socially isolated, depressed and anxious (Berkley, Beard, & Daus, 2019).

Yet, it is not uncommon for sexual minorities to report that unhelpful situations in therapy result in their not talking about their concerns in therapy (Israel et al., 2008). “Heterosexism assumes the supremacy of social practice, cultural structures and norms, and idioms of heterosexuality” (King et al., 2007, p.8). Most participants in the present study described feeling silenced following their therapists’ heterosexist responses. Consistently, LGB-identified participants in a study by Dorland and Fischer (2001) reported being more willing to talk about matters around their sexual orientation when the therapist’s language was free of heterosexist bias. Furthermore, Bowers, Plummer and Minichiello’s (2005) study showed that sexual minorities might find it difficult to talk openly with a heterosexual therapist. However, in the present study Thomas, who had a gay therapist, also described not feeling “able to discuss anything related to sex relationships in any sort of details since then”. As also discussed in the subtheme above, Thomas’ words can highlight that being acknowledged as a gay person in therapy is not enough; one needs to be validated with their individual expression of being gay regardless of the therapist’s sexual orientation (Goettsche, 2015).

Similar to the participants of the present study, some gay men in the Mair and Izzard (2001) study described not talking openly about matters regarding their sexual identity in therapy because of fear of being judged or misunderstood. Other participants in the same study implied that their therapists themselves were ‘silenced’ when it came to talking about sexual experiences, making them feel inhibited or silenced too. Hopcke, Carrington and Wirth (1993) mentioned that, for a gay man, sexuality is a very important way of being in the world. Thus, the difficulty to express a gay identity should be taken into consideration when it comes to SIGM clients, such as the participants of this study.

Contrary to the unhelpful and silencing experiences of the participants of this study, Pixton's (2003) and Lebolt's (1999) participants reported that their 'affirmative therapy' allowed them to relax and talk more freely as they did not feel judged or misunderstood. This experience confirms Malyon's (1982/1995) recommendation that the therapist's unconditional acceptance of the client's gay identity can facilitate the free expression of one's sexual orientation, providing a corrective and very different experience to the client's homophobic socialization.

#### **5.2.2.3. *No space for client in therapy***

The descriptions of the participants revealed that their therapists' responses made them feel like there was no space for them in therapy to explore their own experience of being a gay man. They described their therapist taking over their space with their own agenda and opinions instead of responding to what the participants as clients wanted to talk about.

The experiences of the participants in this study contrasted with Schmid's (2002) description of the 'Thou-I' therapeutic relationship (based on Buber's (1958) 'I-Thou' attitude), where the experience of the client remains the priority. Accordingly, the therapist's task is to empathically try to perceive and understand the essence of this experience (Mearns & Cooper, 2018). Consistent with James's description of terminating his therapy, a recent meta-analysis by Swift, Callahan, Cooper and Parkin (2018) showed that giving space to the client's preference of how the therapy is run is linked with fewer treatment dropouts. These findings from literature regarding the general population could be particularly relevant to clients with a minority status. Hook, Davis, Owen, Worthington and Utsey (2013) mentioned that therapists need to acknowledge that their own beliefs and values are not superior to culturally different clients, in order to work therapeutically with them.

Based on the accounts of his sexual minority participants, Milton (1999) emphasised how giving a safe space to clients can help them develop new fulfilling and meaningful understandings of their sexual identities. In the Israel et al. (2008) study, participants reported as unhelpful when the therapists used excessive self-disclosure or enforced their values and judgment, such as negative biases regarding sexual orientation. Furthermore, participants in the Bowers et al. (2005) study referred to the therapists' assumptions and stereotypes missing the points of the client. Indeed, in the present study Manuel talked about feeling dismissed by a condescending therapist who followed her own agenda. Consistently, participants in the Bowie et al. (2016) qualitative research study described as unhelpful when the therapists followed their own agenda regardless

of what the client needed or wanted. Similar to Manuel, their participants also reported feeling invalidated, and perceiving a sense of arrogance and superiority from their therapists.

Consistently, Lebolt's (1999) participants described as helpful when their affirmative therapist was "attentive" and an active listener, giving them the space to reflect and talk. Pixton's (2003) participants described as helpful when their therapist was able to acknowledge the client's uniqueness and respond to their needs appropriately. Recently, some participants in Quiñones, Woodward and Pantalone's (2017) study reported as helpful when the therapist proactively encouraged clients to set the direction of therapy themselves in a safe, validating and non-judgmental manner.

The presenting findings illuminated how clients may perceive their therapist's self-disclosures as intrusive. In Goettsche's (2015) study some participants also described experiencing therapists' self-disclosure as intrusive. Milton (1999) mentioned that often, sexual minorities do not have the space to explore their identities, freely, in their life. Thus, it is dangerous for therapists to also impose meanings onto these clients' experiences in therapy. Interestingly, participants in studies by Lebolt (1999) and Israel et al. (2008) described therapist's self-disclosures as both helpful and unhelpful depending on the contexts and their different preferences. Literature regarding the general population seems to agree that thoughtful therapist disclosure can enhance the therapeutic relationship (Barrett & Berman, 2001; Zur, 2011). Consistent with the experiences of the participants of the present study, however, disclosures are more likely to be experienced as unhelpful when the therapeutic relationship is rated as negative (Meyers & Hayes, 2006). Several authors (Bloomgarden & Mennuti, 2009; Knox & Hill, 2003; Zur, 2011) therefore encourage therapists to be sensitive to client responses around the impact of their disclosures.

#### **5.2.2.4. "You don't get to see the full picture"**

Participants described having to exclude certain aspects of their experiences specifically linked to their individual gay identity in therapy. This did not allow them to bring their "full picture" (Manuel) of *being* into therapy. Participants expressed feelings of mistrust towards the therapist, and disappointment and annoyance about not receiving the support they were hoping for, because of their gay identity. These experiences echoed a sense of being compartmentalised and disintegrated in therapy.

Thomas described his therapist's subtle behaviours and posture to make him feel rejected as a gay man and sexual being. This is consistent with findings that subtle prejudice in therapy may be perceived through subtle dismissive gestures and snubs



(Constantine & Sue, 2007). Similar to the participants in the present research, Mair and Izzard's (2001) participants felt that their therapists did not see their sexuality as a part of the whole and that their sexual orientation was not integrated into their therapy process. Some participants in Waehler's (2008) study also felt rejected when they sensed their therapist to feel uncomfortable when talking about their sexual identity. Participants in the Shelton and Delgado-Romero (2011) study also described perceiving their therapists to actively avoid or silence their sexual orientation. King et al. (2007) discussed how such discriminatory experiences, because of ignorance or hostility to sexual minority matters, can leave clients feeling stereotyped and misunderstood.

The present finding support Pixton's (2003) insight that clients perceive as important when therapists have a holistic view of their sexuality and their well-being. Pixton's participants felt seen and accepted as a whole person in therapy and mentioned feeling more accepting of their sexuality and more able to integrate it within themselves as a result. Similar findings were reported in Lebolt's (1999) study. Consistently, Mearns and Cooper (2018) talk about the therapeutic benefit of the therapist attending to and affirming the 'whole' of the client. Only then moments of *relational depth* become possible, as the client can feel listened to and accepted as a whole.

### **5.2.3. Master Theme 3: UNDERSTANDING THE IMPACT OF UNHELPFUL INCIDENTS OUTSIDE THERAPY**

#### **5.2.3.1. *"I wasn't feeling like I belonged in my skin"***

Participants described the unhelpful therapy incidents to have an impact on how they experienced or expressed themselves. James and Omar described developing a negative sense of self and feeling disconnected. Chris and Manuel, however, described taking a more empowering stance towards themselves as gay men.

James' and Omar's descriptions can support the theories that internalised sexual stigma can result in self-hatred and self-devaluation (Moradi et al., 2009). Consistently, findings of Israel et al. (2008) indicate that unhelpful therapy situations negatively impact the self-acceptance and quality of life of their participants. Mair (2003) mentioned that his participants expressed shame and self-hatred following their unhelpful experiences in therapy. Self-hatred can be heard in James's account of not trusting himself and his body. James's visceral descriptions, such as "I wasn't feeling like I belonged in my skin" and "feeling sick in my skin" illuminate the embodied and embedded nature of one's experience of self in the world, as illustrated by Merleau-Ponty (1962).

Such findings are consistent with the concept that sexual minorities can experience a societal rejection, which affects their psychological well-being, including their relationship with themselves (Nel & Joubert, 1997). Feminist thinking and Relational Cultural Theory stress power dynamics in relationships and clarify that people may behave according to their internalised relational images in their interpersonal interactions (Jordan, 2009). Accordingly, as also described by James and Omar, power dynamics in the therapist-client relationship can have an important impact as to how the gay male client is experiencing and enacting his internalised homophobia (Mereish & Poteat, 2015).

Moreover, James's and Omar's accounts can remind us of the notion that the way an individual relates to themselves can be the internalised pattern of how others have related to them (Vygotsky, 1962). Several researchers (Bowers et al., 2005; Shelton & Delgado-Romero, 2011) argue that even therapists who oppose heterosexism may still unintentionally perpetuate the gay client's societal or psychological stigmatisation. In a recent meta-analysis, Elliott, Bohart, Watson and Murphy (2018) illuminated the therapeutic benefit of the therapist's empathic responses and discussed the importance of therapists being sensitive to the possible impact of societal discrimination and perceived microaggressions when working with diverse clients. Although Elliot et al. (2018) did not specifically mention sexual minorities, their point seems highly relevant for gay clients too. Such an empathic experience could allow clients to meet at *relational depth* with their therapist and help them relate in more meaningful ways to themselves (Mearns & Cooper, 2018).

Indeed, some participants in the study by Nel et al. (2007) reported that their accepting therapy experience helped them with their self-loathing and had a positive impact on their self-acceptance and self-esteem. Therapists in Milton's (1999) study described that the purpose of therapy is to facilitate the client's self-relationship. Indeed, client participants in the same study confirmed this by describing an enhancement in their relationship with themselves and developing a more positive outlook toward their sexual identity.

An interesting finding of the present research that contrasts with the aforementioned studies is that participants like Chris and Manuel managed to experience and express self-affirmation regardless of their unhelpful experiences in therapy. Chris seemed to combat the negative effect by visibly expressing his individual gay identity as a defence against the oppressive 'gay-blind' practice. Manuel described feeling "proud" as this experience for him meant that he managed to face his fear of "homophobia" and that he

managed to develop a belief in himself regardless of the unhelpful therapy. This finding is consistent with humanistic theories that emphasise the concept of “choice” in one’s experience and direction when faced with challenges (Schneider & Krug, 2010) and with the concept of *actualising tendency* (Rogers, 1995).

#### **5.2.3.2. Relationships outside therapy experienced as supportive or challenging**

Participants seemed to experience their relationships as either particularly supportive or challenging following the unhelpful incidents in their therapy. Chris and Brian described pursuing understanding from people through their training and work settings. These relationships were described as providing them with what the therapy experience was not able to offer: safety, support and validation. Conversely, James and Thomas described feeling threatened and thus more guarded, keeping other people at a distance.

Although there is plenty of research indicating that therapy can improve the experience of relationships (Norcross & Wampold, 2018), research on how unhelpful experiences in therapy affect relationships outside therapy remains sparse. Relational Cultural Theory would argue that people create “relational images” based on their internalised experiences of connection and disconnection (Jordan, 2009). Similar to such experiences occurring in childhood and in society, the exposure of gay men to a heterosexist and homophobic therapy could lead to an experience of internal homophobia (Davies, 1996a). This could impact their relationships with others who might represent the part of themselves that is loathed (O’Carroll, 1999). Accordingly, experiences of relational disconnection (such as rejection based on sexual identity in therapy) could have influenced the internalised mental “relational images” of James and Thomas and negatively affected their intimate relationships with other men. This could be highly illustrative of how one’s historical and socio-political context can shape their subjective experiences (Eatough & Smith, 2008).

Similar to this study, the participants in the study of Israel et al. (2008) who described their therapists as cold, disrespectful and disengaged reported their relationships outside therapy being impacted negatively. Moreover, in Waehler’s (2008) study, some gay men and lesbian women reported engaging in social withdrawal and fighting with others following negative incidents in therapy. More women participants reported feeling angry and confused than men. More women than men also expressed regret for not using more support systems to manage the negative impact. In the present research both responses were reported by men, indicating that perhaps gender does not determine one’s emotional and behavioural responses to such unhelpful incidents.

Throughout their interviews the participants of this study expressed not feeling able to communicate about these unhelpful experiences with their therapists. Winnicott (1969) would argue that only when clients are able to express their dissatisfaction of their relationship with their therapists, will they make sense of it. This will then encourage them to build fulfilling relationships in and out of therapy. Wallin (2007) talking through the lens of Attachment Theory, emphasised how the new relationship with the therapist may allow the client to experience relationships outside therapy as supportive. The client's relationship with the therapist has the potential to alter the emotional and relational experiences outside therapy. Mearns and Cooper (2018) talked about connective experiences in therapy, moments of 'fix' (Stern, 2004) that can remind the client that they belong to the human world. This can help them develop the confidence and skills to relate to other people in a similarly fulfilling pattern (Mearns & Cooper, 2018).

Although these theories seem consistent with what the participants in the present study were missing, some of the participants described managing to build positive and supportive relationships outside therapy regardless of their unhelpful therapy experiences, thus challenging the aforementioned theories. Chris's and Brian's descriptions revealed that unhelpful therapy experiences encouraged them to get in touch with what they actually wanted but were missing, and to look for it elsewhere. As will also be discussed below, this is consistent with research focusing on resilience and sexual minorities (e.g., Herrick et al., 2011; Mereish & Poteat, 2015). For example, Mereish and Poteat (2015) demonstrated that, because of their adverse experiences, sexual minorities may develop a resilience that helps them build supportive and fulfilling relationships which help them manage psychological distress.

#### **5.2.3.3. *Finding a way forward***

Participants appeared to emphasise that following the unhelpful experience they managed to help themselves move forward. Regardless of the negative responses from their therapists, the participants managed to seek what was good for them. These descriptions are in line with those of Mair and Izzard's (2001) gay male participants, who reported personal growth 'in spite of' their unhelpful experience with their therapists.

Most participants described supportive relationships as helping them move forward. Participants in Waehler's (2008) study also reported being able to move forward from unhelpful therapy experiences through supportive connections. Consistent with Relational Cultural Theory, Mereish and Poteat (2015) indicated that when sexual minorities have supportive relationships they report less psychological distress than

when they do not. However, the nature and quality of these relationships were not explored. The participants of the present research described forming such interpersonal connections in the context of therapy, friendships or caring people. These people were described as supportive and informed about sexual minority matters and thus able to help the participants move forward from their unhelpful experiences. Such coping strategies have been reported by sexual minority adolescents when dealing with minority stress (Goldbach & Gibbs, 2015).

Relational support was not the case for James. James described feeling good about managing to move forward by doing the work himself in his therapy. This idiosyncratic conceptualisation can support the notion that human experiences are contextually embedded and bound (Eatough & Smith, 2008; Smith et al., 2009). For example, in his interview James described how prior to therapy he did not have support from his family and how he had to manage on his own. James was also the only participant who mentioned his therapist implying that an event in his life turned him gay. Perhaps during that time of continually having no support from important people in his life it was important for James to feel like he could cope on his own.

That all participants eventually managed to turn something unhelpful into something helpful supports the emerging research focusing on resilience as a protective factor for psychological wellbeing among gay men and other sexual minorities (Herek & Garnets, 2007; Herrick et al., 2011; Lim et al., 2012; Bruce, Harper, & Bauermeister, 2015). It is assumed that gay men could have developed resiliency and coping mechanisms because of the years of stigmatization from a heteronormative if not homophobic society (D'Augelli & Hershberger, 1993; DiFulvio, 2011; Rosario, Hunter, Maguen, Gwadz, & Smith, 2001), and even mental health services (Russell & Richards, 2003). Waehler (2008) proposed that this resiliency has allowed gay men to move forward from unhelpful and even harmful therapy experiences. It is difficult, however, to generalise from the above theories about resilience to the participants of the present study, as other developmental factors may have contributed to its emergence (Kumpfer, 2002; Shilo, Antebi, & Mor, 2015).

### **5.3. Critical Discussion**

#### **5.3.1. *Limitations***

Smith et al. (2009) clarify that IPA with its hermeneutic and idiographic underpinnings takes contextual factors into consideration to understand the cultural position of one's experience. However, though IPA's focus on the perceptions of a phenomenon can offer an understanding of the lived experience, it is limited in explaining why this experience

emerged and the contribution of past events and sociocultural factors and the processes involved (Willig 2013).

Moreover, culture is internalised and communicated through language (Ji, Zhang, & Nisbett, 2004). Thus, James's, Omar's and Thomas's experiences may have been represented differently in English compared to their native language. The same could apply for how they recollected and interpreted the unhelpful incidents (Marian & Neisser, 2000) and organised and expressed their emotional experiences (Kitayama & Markus, 1994; Wierzbicka, 2004). Eatough and Smith (2008) argue that language is crucial in constructing our lifeworld and shapes our subjective experiences. Thus, interviews that were not conducted in participants' native language may not have fully captured the richness and depth of their experiences and sense-making.

IPA is criticized for not placing enough emphasis on the importance of language (Willig, 2013). Still, in IPA, Smith et al. (2009) argue that one's experience is intertwined with language. As such, in the present study the context of participants' narratives and their use of words and metaphors were taken into account, allowing for a deeper insight into their experiences. However, focusing more on the use of language could be particularly relevant in understanding how the psychotherapy/counselling training of the participants who were therapists might have impacted their portrayal of their experiences.

Critical Narrative Analysis (CNA), whilst a phenomenological approach, focuses on the construction of narratives and uses aspects of social theory to understand them (Langdridge, 2007). Considering all the above, CNA could be a suitable approach to get an insight into the meanings SIGM clients give to their unhelpful experiences in therapy, taking also into consideration sociocultural, historical and political factors. However, my lack of knowledge and experience using this approach and the time limitation of a doctoral research meant that it was difficult for myself to consider it.

Moreover, pluralistic qualitative research, such as combining IPA with Foucauldian Discourse Analysis or Grounded Theory could have offered a more thorough understanding of the unhelpful incidents in therapy as experienced by SIGM and what conditions triggered this phenomenon and why (Eatough & Smith, 2008). The concept of pluralism itself encourages the recognition of multiple competing perspectives when exploring a phenomenon (McAteer, 2010). Again, I considered that this would not be possible considering that pluralistic designs can be time consuming (Frost, 2011) and doctorate research is time-limited.

IPA is sometimes criticised for capturing the opinions of an experience rather than the meanings of an experience and the experience itself (Tuffour, 2017). This is more likely

to happen when participants struggle to articulate their experiences fluently (Willig, 2013), especially if the topic is sensitive, such as mental health (Tuffour, 2017). I attended to this criticism by endeavouring to collect rich and exhaustive data from participants during the interview about the cognitive and emotional experience of the phenomenon under investigation. The phenomenological underpinnings of IPA, however, have been criticised for not being consistent with the role of cognition. Unlike cognitive psychology, phenomenologists challenge the separation between subject (the person) and object (the world) (Willig, 2013). Phenomenology captures how the world manifests itself to a person and accounts for vague feelings “on the margin of consciousness” (O’Connor & Hallam, 2000, p.245). Nonetheless, Smith et al. (2009) state that IPA’s focus on sense-making and meaning-making implies a reflective process that is compatible with cognitive psychology.

The small sample size of the present study meant a better commitment to the idiographic element of IPA, whilst still allowing for convergence and divergence between the accounts of different participants (Smith et al., 2009). Still, as Collins and Nicolson (2002) stated, the process of searching for similarities and differences between accounts “misses a potentially richer seam of data, that of a contextualised, unfolding and sequential account within a single interview” (p.627). Indeed, during the analysis I often felt that I was excluding some depth for breath, losing the sequential nature of an individual experience (Brocki & Wearden, 2006).

IPA uses a purposive and homogeneous sample in order to provide a thorough perspective of the phenomenon of interest (Smith et al., 2009). The sample of the present research was homogeneous, as it consisted of SIGM who had an unhelpful experience in therapy linked to their sexual orientation. However, they were men of different ages and cultural backgrounds. Such heterogeneity could be considered to capture a diversity of perspectives and to represent the SIGM clients attending therapy in the United Kingdom. This could allow some transferability of these findings (Carradice, Shankland, & Beail, 2002). However, the homogeneity of the sampling also means a limited transferability and comparisons of the findings among other sexual minorities, such as self-identified bisexual, trans or asexual individuals who are scarcely represented in research on sexual and gender minorities in therapy (Israel et al., 2008; Foster & Scherrer, 2014).

Furthermore, the majority of the participants were white and highly educated. These demographics are commonly overrepresented in the research (Bieschke et al., 2000; Dowsett, 2007). Moreover, there is limited existing research on the phenomenon of

interest. This means that it is still difficult to form a clear understanding of the unhelpful experiences in therapy for SIGM clients of different cultural backgrounds and in comparison to other sexual minorities. Research on the experiences of gay men and other sexual minorities in therapy needs to include experiences with diverse cultural, socioeconomic and educational backgrounds in order to be representative of the experiences of these communities.

Another possible limitation is that all participants described experiences of events that happened several years ago. Such retrospective recollections of internal subjective experiences may be skewed by memory (Dickson, Knussen, & Flowers, 2007). Additionally, a client's evaluation of therapy might change from session to session (Llewelyn, 1988). One limitation of relying on recollections from a while ago is the possibility that clients who found their therapy as helpful overall might find it difficult to recall any hindering experiences in therapy, particularly if the experience was not perceived as severely unhelpful or it was eventually resolved (Henkelman & Paulson, 2006). Therefore, the findings of this study could be limited, not just by memory, but also by how these experiences were mentally reconstructed and given new meanings in time, thus influencing their final presentation in their narratives. However, the advantage of this limitation is that the reader gains an insight of the experience of unhelpful incidents in therapy in the long-term.

A potential participant shared with me that he was no longer interested in being interviewed because he was still struggling with high distress and low mood following his unhelpful therapy experience. Therefore, only people who managed to move forward somewhat from their experiences were interviewed. This might have influenced the findings of this study, such as the finding that all participants described their resilience in moving on from the unhelpful incidents.

It is also important to note the potential social desirability bias (McLeod, 2003) of the findings of this study. It is possible that three of the participants who were therapists themselves might have felt a pressure to articulate their experience using psychological theories or intellectual terms in order to be viewed positively by myself as also a researcher and a researcher of processes in therapy. Nonetheless, the content of the interviews and the expressiveness of the participants seems to suggest a rather open and genuine description of their experiences. Specifically, during or right after the interviews, participants described how they became more in touch with their experience of unhelpful therapy incidents.



Lebolt (1999) discussed how a qualitative method is suitable for researching the experiences of gay men in therapy as it involves complex and subjective processes that are difficult to be quantified. However, not all participants in this study presented the identified themes equally; some emphasised or described these experiences more extensively than others. Thus, the reader is encouraged to consider the generalisation of the findings with caution.

Finally, IPA's focus on one's perceptions means it is not possible to know the exact responses of the therapists that triggered the experiences the SIGM participants shared in this study. Mair (2003) warns us of the potential impact of internalised homophobia of the participants on their perception of the unhelpful incidents in therapy. As Davies (1996b) mentioned: 'It is unusual...for a gay client to present for therapy saying they hate themselves because they are gay....Their internalised homophobia is more likely to come out through subtler means' (p. 58). Whilst this is something for the reader to consider when looking through the findings of this study, understanding them as simply projections/transference would dismiss the different levels of homophobia that are inevitably manifested in the consulting room (Izzard, 2000).

### **5.3.2. Strengths**

Despite the aforementioned limitations, it is worth noting that the findings of the present research are to a great extent consistent with existing literature and studies on unhelpful experiences of SIGM in therapy. As discussed below, these findings could be used as insights for further research and practical applicability. They could also invite readers to evaluate these insights based on their existing theoretical knowledge and clinical experience and to expand their empathic understanding of SIGM in therapy (Smith & Osborn, 2008).

Similar to previous research (e.g., Elliott, 1985; Llewelyn, Elliott, Shapiro, Firth-Cozens, & Hardy, 1988; Paulson et al., 2001; Swift et al., 2017) the present study illuminated how clients might experience hindering or unhelpful incidents in therapy, such as perceiving negative therapist reactions and feeling misunderstood. Moving a step further from these studies, the present study recognised the diversity of clients in therapy and took into consideration reports suggesting that sexual minorities are more likely to have negative experiences in therapy than their heterosexual counterparts (Crawford et al., 2016; Elliott et al., 2015). The qualitative nature of the present study gave voice to participants and allowed deeper insights that many previous reports did not. For example, participants in the Crawford et al. (2016) study stated that the simple term of 'negative' could not give an account of how difficult their experience in therapy was.

However, the present research offered insights supporting or adding to the limited research on sexual minorities and particularly on SIGM.

Grafanaki and McLeod (1999) acknowledged that there is no sharp line distinguishing helpful and unhelpful events in their study. Swift et al. (2017) also found that therapist's responses to the same incidents in therapy were perceived by different clients as either highly helpful or highly hindering. The qualitative nature of the present study allowed for deeper understandings about the unhelpful experiences of SIGM in therapy, thus accounting for individual variations of contextual and complex perspectives (Hoshmand, 1989; Ponterotto, 2005). The use of IPA in particular made it possible to explore participants' processes about the phenomenon of interest whilst emphasising their individual experience (Hoyt & Bhati, 2007; Osborn, 1990). The small number of participants allowed more thorough and deeper exploration of these individual experiences (Smith et al., 2009; Smith & Eatough, 2006).

The specific focus on unhelpful experiences of SIGM in therapy can encourage the mental health practitioner to develop multicultural competence. Several scholars (Coleman, 1998; Fuentres & Brobst, 2002) argue that multicultural competence is essential for clinical competence because of the diverse populations using mental health services. As Sue (2004) stated, "a psychology that does not recognize and practice diversity is a psychology that is truly bankrupt in understanding the totality of the human condition" (p. 766-767).

Considering that many of the participants eventually left therapy prematurely, the findings of this study may also fill gaps from previous research exploring the different factors contributing to therapy drop-outs (e.g., Rubin, Dolev, & Zilcha-Mano, 2018; O'Keeffe, Martin, Goodyer, Wilkinson, & Midgley, 2018). Such studies did not take into account how experiences of microaggressions and discrimination in therapy may impact the engagement of clients in the therapeutic process. However, the present study using IPA was able to "determine what an experience means for the persons who have had the experience and are able to provide a comprehensive description of it" (Moustakas, 1994, p. 13).

Moreover, the fact that the present study included the experiences of SIGM who managed to move forward from their unhelpful experiences in therapy shed light upon the concept of resilience amongst SIGM clients. There is little attention given to the concept of resilience amongst SIGM in therapy in relevant past research (Waehler, 2008). Nonetheless, the field of Counselling Psychology with its humanistic values appreciates the consideration of one's potential for *self-actualisation* when working

therapeutically (Douglas et al., 2016). Furthermore, the British Psychological Society recently proposed “the power threat meaning framework” when formulating and working with mental health difficulties. As opposed to functional psychiatric diagnosis, this framework also acknowledges the importance of mental health clinicians considering and building on the concept of resilience when working with clients in distress (Johnstone et al., 2018).

### **5.3.3. Methodological Reflexivity**

Qualitative research recognises that the researchers bring their own biases to the analysis of the data (Willig, 2013). Thus, employing IPA meant that my own *lifeworld* would influence the interpretative process (Smith et al., 2009), impacting the validity and reliability of the findings as a result (Golsworthy & Coyle, 2001). Despite the effort to recognise and ‘bracket’ my biases, preconceptions and existing knowledge, the literature explored in the first chapter, as well as my interest in the relational approaches of understanding the human experience, might have contributed to a bias when constructing the interviews and interpreting the data. To manage that, I aimed to generate my interpretations based on my participants’ extracts and interviews through a *hermeneutic circle* and through ‘triangulation’ of my findings by involving my supervisor and a colleague. Additionally, the extracts presented could allow the reader to evaluate whether the presented analysis and interpretations are in keeping with the data (Smith et al., 2009).

Moreover, the descriptions of the experiences of the participants might have been different if they were shared in a different relational context, mood or setting. As Schrödinger (1935) demonstrated, the scientist inevitably influences the phenomena under investigation. It is important to acknowledge the possibility that the way the interview was constructed, and my verbal and non-verbal responses to their stories, might have impacted the accounts shared. Whilst acknowledging these possible influences, it is also important to note that, for the analysis of the data, the participants’ accounts, their nonverbal communications and my own visceral reactions to their material upon trying to capture their perspectives were taken into consideration.

Consistent with Heidegger’s view on ‘bracketing’ (“*epoché*”) (Langdridge, 2007), my *Hermeneutic Realism* ontology assumes that my experiences and assumptions inevitably guided the analysis of the data (Slife & Christensen, 2013). My interest in the topic of unhelpful therapy experiences for SIGM clients arose during my interactions with other therapists when I perceived them to display some stereotypical and discriminatory thinking. As a qualitative researcher it was important that I was aware of the ways in

which my own experience and assumptions may have limited or facilitated the reading of the qualitative data (Willig, 2012). In order to be aware of when and how my own experience impacted the analysis of my participants' accounts, I kept reflecting on it in my subsequent personal therapy, my research journal and my research supervision.

As I am also an SIGM, I am affected and concerned about discrimination based on sexual orientation. As a practitioner I embrace a pluralistic approach to therapy, which encourages a collaborative framework of working with clients, and values their feedback as vital for guiding the therapy process (Cooper & Dryden, 2015). Therefore, I saw this study as a process of gathering feedback about unhelpful experiences in therapy in relation to one's sexual orientation, particularly as these experiences are often too difficult to talk about in therapy. It is my hope that the presented findings will invite a deeper understanding of the participants' experiences. This could allow the reader who is also a mental health practitioner to nurture the compassion and empathy to attune to their SIGM clients in an ethical and helpful manner. Furthermore, it could help me as a therapist to expand my empathic understanding and see beyond my own assumptions and personal experiences regarding this phenomenon in order to better attune to and help my SIGM clients (see Appendix K, notes from my research journal).

Indeed, the accounts of my participants helped me appreciate the diversity that may exist amongst SIGM clients regarding their perceptions and experiences of unhelpful events in therapy. For example, it was useful for me to understand that, whereas some SIGM clients might feel frustration and anger towards their therapist following unhelpful incidents, others might experience a profound self-loathing instead. The findings encouraged me to become aware of the importance of actively and empathically listening to SIGM clients in order to 'hear' what might be experienced as unhelpful or rejecting towards their sexual orientation yet not talked about. And as I reflect on this learning I am reminded of Rogers' (1995) words: "we think we listen, but very rarely do we listen with real understanding, true empathy" (p.116). It is for this reason that following my engagement with this study I have come to value the usefulness of qualitative methods in investigating and shedding light onto processes that are crucial for good quality clinical practice.

#### **5.3.4. *Epistemological reflexivity***

The present research has achieved its aim to offer an insight into the experience and meaning-making of unhelpful incidents in therapy that were perceived to be related to the sexual orientation of six SIGM clients. The findings of the research can help the

reader gain an understanding of how these unhelpful experiences have impacted the therapeutic processes of SIGM.

The knowledge emerged through the lens of an epistemological 'middle ground' position between *Critical Realism* and *Relativism* (Willig, 2013) and a *Hermeneutic Realism* ontological position (Slife & Christensen, 2013). The epistemological stance assumes that the interview data can show us a glimpse of the several 'realities' that are the SIGM's lived experiences of unhelpful incidents in therapy in relation to their sexual orientation. It is possible that in another context and with another interviewer the data would have illuminated other 'realities'. The *Hermeneutic Realism* ontological position assumes that the data consists of realities that are in fact the *meanings* the participants have for unhelpful incidents in therapy in relation to one's sexual orientation. Like objects, these meanings are grounded in the reality of the world. However, unlike objects, they can change according to context and they are impacted by relational processes.

The knowledge created by the present research is *phenomenological* (Willig, 2012), as it illustrates the quality and texture of SIGM clients' unhelpful experiences in therapy. Furthermore, the interpretative analysis of the data "positions the initial 'description' in relation to a wider social, cultural, and perhaps even theoretical, context .This second-order account aims to provide a critical and conceptual commentary upon the participants' personal 'sense-making' activities" (Larkin, Watts, & Clifton, 2006, p. 104). As such, the knowledge created for this study goes beyond the phenomenological level, taking contextual factors into account. Also, it is intersubjective, that is, co-created and co-authored by the researcher and participant (Slife & Christensen, 2013), a process also described in IPA as a *double hermeneutic* (Smith et al., 2009).

### **5.3.5. Research Evaluation**

Having implemented Smith's (2011) four IPA-specific criteria to evaluate IPA research (see Methodology chapter) the present study could be considered as sufficient. Other qualitative researchers (e.g., Forshaw, 2007) advocate that the aim of qualitative research is to evoke a debate rather than to produce insights with some validity. From this perspective, the readers can use this research to engage in discussions regarding unhelpful practices in therapy among SIGM and other sexual minorities. Qualitative phenomenological research in particular can be used productively to inform recommendations for improved therapeutic practice (Willig, 2013). Therapy experience is interpersonal and such research findings can be transferred and may have "relevance if applied to other individuals, contexts and situations" (Finlay, 2006, p.320). In the

remainder of this chapter I will discuss the relevance of this research to Counselling Psychology and I will propose its implications for clinical practice, training and future research.

#### **5.3.6. *Relevance to Counselling Psychology***

Strawbridge and Woolfe (2003) described Counselling Psychology as the application of psychological knowledge to the practice of therapy. The British Psychological Society Division of Counselling Psychology (2005) guidelines support the use of phenomenological approaches for research and practice that "...marry the scientific demand for rigorous empirical inquiry with a firm value base grounded in the primacy of the counselling/psychotherapeutic relationship" (p.1). Consistently, the present research with its qualitative phenomenological method explored a phenomenon that is relevant to the research and clinical practice of Counselling Psychology and can therefore inform research-led practice. The present research aimed to complement existing quantitative and qualitative studies on the unhelpful experiences of gay men in therapy. The use of IPA allowed the deeper exploration of the subjective lived experiences of unhelpful incidents SIGM clients had in therapy (Smith et al., 2009). IPA seems compatible with the humanistic ethos that emphasises subjectivity and intersubjectivity and underpins Counselling Psychology (Douglas et al., 2016).

Counselling Psychology has a vital role in researching and advocating for social justice. (Douglas et al., 2016; Toporek et al., 2006; Milton, 2010; Moradi et al., 2010). Toporek et al. (2006) discussed the ability of Counselling Psychologists to formulate and intervene on multiple levels and within systems that can be linked to social justice issues. Therefore, it is important that Counselling Psychologists are competent in understanding the dynamic impact of the factors oppressing the system and skilled in designing and implementing interventions and policies that can enhance suitable systemic solutions. The present research focuses on the experience of rejection and discrimination in therapy of a socially marginalised group. This can invite Counselling Psychologists and their training institutions to become more sensitive about the different levels of oppression and privilege, and contemplate ways to tackle discrimination about sexual orientation in research and practice, and within the community (Douglas et al., 2016).

#### **5.3.7. *Implications for training and practice***

It is hoped that the present research might influence the training and practice of Counselling Psychology. Based on the three learning points from the 'Synthesis of

Findings' section above, I propose some implications for training and practice with SIGM clients:

#### 5.3.7.1 The experience of a dismissive, stereotyping and unempathic therapist

This learning point can help training programmes and practitioners gain a wider understanding why some SIGM clients may not engage in therapy or drop out. Participants described their initial motivation to engage in and even keep going back to therapy, yet they also reported feeling disengaged from it following their unhelpful experiences. The present finding can complement the *Stages of Change Theory* proposed by Prochaska and Norcross (1994). Consistent with this theory is evidence that clients' lack of readiness and low motivation affect their engagement with therapy (e.g., Paulson et al., 2001). However, the findings of the present research indicate that additional things need to be considered besides the client's initial motivation in order to understand one's level of engagement with therapy.

A consistent finding comes from Dorland and Fischer's (2001) study, where sexual minority clients reported greater engagement with therapy when they perceived their therapists to be inclusive of their sexual orientation. The participants in the current study described a profound sense of disconnection from their therapists and not feeling understood following the unhelpful incidents. Rhodes et al. (1994) indicated that the therapist's lack of capacity to manage misunderstandings can result in client dissatisfaction. Similarly, the findings of the present research can encourage therapists to prioritise building and maintaining safe and collaborative therapeutic relationships in order to manage unhelpful incidents in therapy.

The participants of this study described feeling stereotyped, invisible and rejected following the unhelpful incidents. These findings can complement the findings of Crawford et al. (2016), which urge initial and subsequent professional development training in cultural competence when working with SIGM. I would agree with the notion that anti-oppressive/anti-discriminatory practice is both ethical and best practice (Lago & Smith, 2010). Of course there will always be gaps in knowledge and experience. This is why it is important that therapists genuinely reflect on their blind spots and seek new learning and understanding in order to remain attuned to "their client's uniqueness as an individual sexual and gendered human being" (Lago & Smith, 2010; p. 51). Such a skill is consistent with the training that Counselling Psychology programmes offer and emphasises reflective practice, subjective experience and the importance of the therapeutic relationship (Douglas et al., 2016).

#### 5.3.7.2. The discriminatory practice affected clients harmfully on an intrapersonal and interpersonal level

The participants talked about how harmful the discriminatory practice was to the relationship with themselves and other people. They also shared that they remained in therapy for a while regardless of this unhelpful experience. Above, I discussed how the present study may help us understand the SIGM clients' disengagement in therapy. Here, I discuss how it can help us understand that SIGM attending their sessions does not always imply that the therapy offered is experienced as helpful.

Often therapists find it difficult to sense what is not talked about in therapy (Regan & Hill, 1992) and clients might also not be aware of how much experiences of rejection may impact them (Shelton & Delgado-Romero, 2011). Such accumulated experiences can create a hostile environment that is difficult to work in (Shelton & Delgado-Romero, 2011) and that undermines therapeutic progress (Sue, 2010), even when unhelpful experiences are the result of transference or projection (see Mair, 2003). The present study calls for all therapists to consider reflexively the impact of all their responses on their SIGM clients and be sensitive as to when unspoken ruptures in the therapeutic relationship may occur. Lingardi, Holmqvist and Safran (2016) have discussed the beneficial effect of attending to all levels of the therapeutic relationship, such as *the real relationship* (Gelso, 2009), *transference* (Bradley, Heim, & Westen, 2005), *countertransference* (Betan, Heim, Zittel, & Westen, 2005; Colli, Tanzilli, Dimaggio, & Lingardi, 2014) and *empathy* (Elliott, Bohart, Watson, & Greenberg, 2011).

Safran and Muran's (2000, 2006) considerable work on ruptures in therapy suggests that reparation begins with therapists validating the experience of the client. By employing IPA and giving voice to the lived experience of unhelpful incidents in SIGM's therapy the present study offered a flavour of these experiences. This can encourage clinicians to be more sensitive in identifying them, validating them and acknowledging their contribution to them. Such a process is crucial in cross-cultural therapeutic encounters, as misunderstandings are often inevitable (Keenan, Tsang, Bogo, & George, 2005). Therapists facilitate the process of therapy and it is their role to identify and repair unhelpful experiences (Henkelman & Paulson, 2006; Safran & Muran, 2000). There are different ways to invite in-session feedback safely (e.g., Duncan & Miller, 2000; Johnson & Shaha, 1996; Lambert et al., 2001; Henkelman & Paulson, 2006) something that needs to be incorporated more in trainings and supervisions and adjusted to SIGM clients.



#### 5.3.7.3. The importance of social support for SIGM clients

Finally, all participants of this study expressed a sense of loneliness that was accompanied by a deep hope of feeling understood and connected to another human. Most of the participants, however, shared that they managed to move forward from the unhelpful incidents in therapy through supportive interpersonal relationships. As discussed, existing literature supports a link between social support and resilience amongst sexual minorities. Bartos and Langdridge (2019) have argued that the current understanding of resilience in psychology is too individualistic. They therefore call for a more relational understanding of the LGBTQ resilience that goes beyond the ability of an individual to sustain themselves when encountering adversity and encourages community creativity.

Consistently, the findings of this study can be used to develop more therapeutic support group options for SIGM clients asking for therapy in mental health services in the UK. As other studies have shown (e.g., Nel et al., 2007), such affirmative groups could possibly empower and help SIGM clients to deal with self-acceptance, loneliness and other life difficulties not necessarily or directly linked to their sexual orientation. As discussed above in the Relevance to Counselling Psychology section, such a collective and relational approach to building one's resilience and well-being is consistent with and validates the ethos and values that underpin the training programmes of Counselling Psychology. Moreover, the present research can encourage all training programmes of Applied Psychology to adopt a more collective and relational approach in understanding resilience amongst sexual and other minorities.

#### **5.3.8. *Implications for further research***

The few qualitative studies available on SIGM's unhelpful therapy experiences have included limited samples. This also limits transferability and comparison of the findings about this topic (Willig, 2013). For a more thorough understanding of these experiences more studies need to be done investigating the phenomenon of interest.

"Counselling and psychotherapy have often been criticised for focusing on the psychology of the individual and on the internal life of the client while ignoring the impact of the social, economic, and cultural environment in which people live." (Feltham & Horton, 2000, p. 24). Therefore, CNA (Langdridge, 2007) and pluralistic methods in qualitative research taking a social constructionist perspective (Parker, 1998) could explore the different ways SIGM construct their unhelpful therapy experiences considering the socio-cultural and socio-political factors that contribute to them.

The present study cannot identify the exact interactions that happened in therapy nor the intentions or biases of the therapists. To better understand what specific dynamics the unhelpful experiences may involve, future studies using IPA could interview both the SIGM clients and their therapists in order to gather both perspectives regarding unhelpful incidents.

Similar to Mair and Izzard's (2001) and Bowers et al.'s (2005) studies, Grounded Theory techniques can be used to identify what SIGM clients describe as unhelpful incidents in therapy and how such incidents impact their perceptions of therapy. The focus of Grounded Theory on social processes could enable the formation of theories regarding patterns of unhelpful verbal and behavioural interactions in therapy and the interpretations SIGM clients give to them (Tweed & Charmaz, 2012). Furthermore, studies using Grounded Theory could explore the processes by which SIGM clients react to unhelpful incidents, such as how they decide whether or not to talk about them to their therapist, find another therapist or drop out from therapy. Such research could create knowledge that can help training programmes and clinical supervisors better monitor how microaggressions or subtle discrimination are enacted and managed in therapy.

Moreover, using methods such as the Interpersonal Process Recall method (Elliott, 1986) could help SIGM clients choose segments of their recorded sessions and explore them as they had occurred. Such micro-process research could gather data based on a moment-by-moment analysis of therapy sessions that quantitative self-report measures and qualitative research on retrospective incidents may miss (Elliott, 2010; Swift et al., 2017).

Participants pinpointed different ways that helped them move forward from their unhelpful incidents. Future research focusing on resilience could explore the resources SIGM clients consider in order to cope with negative therapy experiences. Supportive relationships appeared crucial for most participants. Future research could also explore the unhelpful and helpful experiences of gay men in a group therapy setting (e.g., Nel et al., 2007). Such research could help us understand and could inform other ways than just 1:1 therapeutic contexts of working with SIGM.

Similar studies could focus on different GSRD client groups, especially considering how little existing psychotherapy literature focuses on diverse forms of gender, sexuality and romantic relationships (Barker, 2012). Moreover, most of the participants in the present research were white men and none of them had physical disabilities. Future research could include sexual minorities who are racial/ethnic minorities and /or have a physical

disability. This could allow the exploration of the understudied experiences of intersecting minority statuses (see Hunt, Matthews, Milsom, & Lammel, 2006; Colin, 2010; Balsam, Molina, Beadnell, Simoni, Walters, 2011).

Manuel was the only participant who described an unhelpful incident chronologically relevant to his coming out phase. That is why no theme was identified regarding how the coming out stage may have impacted the unhelpful experiences of the participants. This is something future research can investigate, especially as evidence shows that the level of distress or comfort in identifying as a sexual minority can affect therapy (Jones et al., 2003). Indeed, concealing one's identity can affect one's cognitive, physical and interpersonal experience negatively (Critcher & Ferguson, 2014). Moreover, coming out does not always mean a better state of well-being (Ryan, Legate, & Weinstein, 2015).

## **6. Conclusion**

The present research study was interested in the phenomenon of unhelpful incidents in therapy as experienced by SIGM and perceived to be linked to their sexual orientation. This study employed IPA in order to offer in-depth insights into the lived experiences of six SIGM (aged 25-57). The unhelpful experiences of these participants appeared to be largely coloured by the sense of disconnection they felt with their therapists. These followed an experience of therapy that did not acknowledge them nor embrace them with their unique gay identity. Participants understood these experiences to impact their life outside therapy, their sense of themselves and their interpersonal relationships. Yet, they all managed to move on and find the support they felt that was lacking from their therapy. Counselling Psychology with its appreciation of humans as relational beings and the pluralistic nature of society has been at the forefront of promoting an inclusive and non-pathologising way of working with sexual minorities (Colin, 2010). It is hoped that consistent with British Psychological Society (2012a) guidelines, this research will encourage therapists and researchers to continue pursuing and embracing helpful ways to work therapeutically with SIGM and other sexual, gender and intersecting identities.

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## **8. Appendices**

### ***Appendix A: Flyer***



**Department of Psychology  
City, University of London**

### **PARTICIPANTS NEEDED FOR RESEARCH IN THE UNHELPFUL EXPERIENCES OF GAY MEN IN TALKING THERAPY**

We are looking for volunteers (age 18 +) to take part in a study on  
**'How do self-identified gay men in the UK experience unhelpful incidents in talking therapy'.**

You would be asked to participate in a 1:1 interview and talk about an unhelpful experience you had in therapy that you feel might have been related to your sexual identity.

Your participation would involve one session, of approximately 60-90 minutes and it will take place at City, University of London.

In appreciation for your time, your travel expenses will be covered by the researcher. In order to preserve your privacy, names and identifying features will be anonymised.

For more information about this study, or to take part, please contact:

**Researcher** (*First point of contact*): *Michail Televantos*

*E-mail:* [REDACTED]

**Supervisor** [REDACTED]

*E-mail* [REDACTED]

This study has been reviewed by, and received ethics clearance through the Psychology Department Research Ethics Committee, City, University of London [Reference: *PSYETH (P/L) 16/17 68*].

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on [REDACTED] or via email:  
[REDACTED]

## **Appendix B: Participant Information Sheet**



### **Participant Information Sheet**

#### **Title of study: *'How do self-identified gay men in the UK experience unhelpful incidents in therapy'***

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

#### **What is the purpose of the study?**

The current study aims to explore how unhelpful incidents in talking therapy have been experienced by gay men, considering that these experiences have been perceived to somehow be linked to their sexual identity.

It is hoped that the findings of such research will stimulate Counselling Psychologists and other therapists to expand their empathic understanding of how unhelpful incidents might be experienced by gay male clients. The study is part of a Doctorate programme in Counselling Psychology and it is estimated that it will be completed by September 2018.

#### **Why have I been invited?**

You have been invited to participate in this study as you seem to fit the criteria that can help the present research to investigate the phenomenon of interest in depth and generate meaningful information. These criteria are:

1. You self-identify as a gay man and you are above 18 years of age.
2. You feel you have had an unhelpful experience in talking therapy that you understand to have been related to your sexual identity.
3. You had therapy after the year 2014 and have completed your therapy at least 6 months prior to the interview.

For the same reason, the present study has some exclusion criteria. The participation in this research is not suitable for you if:

1. You are experiencing difficulties impacting your memory/cognitive functioning. This is because the interview will require memory recollection.
2. You experience suicidal thoughts and/or plans and you self-harm. This is because it can be distressing discussing a past unhelpful experience. In this case, please let the researcher know in order to sign-post you to possible services that can offer support.
3. You use substance/drugs and alcohol that affect your memory and perception
4. You take medication that affects your thinking/cognitive abilities. This is because the interviews will entail recalling as accurately as possible accounts of past experiences that can also be particularly distressing.

#### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. You may avoid answering questions which are felt to be too personal or intrusive.

You will not be penalized or disadvantaged in any way by wishing not to participate and by withdrawing your participation at a later time.

### **What will happen if I take part?**

Please take your time to consider your participation in this study. We encourage potential participants to take a minimum of 24 hours to consider their participation. If you decide that you would like to participate, a phone call 'screening interview' will be arranged. This is for us to discuss whether this research is suitable for you. If we agree that this study is suitable for you, you can expect the following:

- We can arrange your interview which will last for approximately 60-90 minutes. Interviews will take place at City, University of London and travel expenses will be provided.
- Prior to the interview, consent will be discussed and you will be given a consent form to sign.
- Prior to the interview you will be given a brief background questionnaire to complete.
- The interview will be 1:1 of semi-structured nature.
- During the interview you will be invited to reflect on your unhelpful experience in therapy. It is important to know that you do not have to share any personal information that you wish not to disclose. The interview will encompass questions that will prompt you to reflect on your unique lived-experience.
- After the interview you will be fully debriefed about the research and you will be asked if you have any questions.
- The research will include the analysis of your anonymized interview and it is possible that it will be published in journals concerned with psychological therapy. The research aims to contribute to a more empathic, individualized and ethical therapeutic practice.
- This research project is part of the Doctorate programme in Counselling Psychology at City, University of London. The plan is for this research to be completed by September, 2018.

### **Expenses**

- Travel expenses for travelling to and from City, University of London for the interview will be provided. For this reason, it is important that you obtain and provide the researcher with your travelling receipts. Travel expenses will be covered whether you have completed the interview or wished to withdraw during the interview. You can expect the payment to be transferred to your bank account within 5 working days after the interview meeting/the provision of the travelling receipts.

### **What do I have to do?**

For the purpose of this research you will be invited to talk and reflect on an unhelpful experience you have had during the course of a talking therapy that you believe to have somehow been related to your sexual identity; how you have experienced it and what meaning(s) you have given to this experience.

### **What are the possible disadvantages and risks of taking part?**

Recalling of a memory of an unhelpful experience might evoke unpleasant emotions and perhaps further negative memories. This is why it is important to reflect on this in the end of the interview and use services of your preferences to ask for the emotional/therapeutic support you may benefit from.

### **What are the possible benefits of taking part?**

Providing your account of your unhelpful experience might help therapists gain awareness of what can be unhelpful in therapy and consider it in their practice with self-identified gay clients. Your emotional experience of it might enhance therapists' empathy and thus help them become more sensitive as to how and what they practise when working with gay men.

Your experience might contribute in opening new windows for research and the development of new therapeutic interventions/approaches when working with gay men and perhaps other sexual minorities.

Finally, speaking about your experience might help you process it even more and see it from a new perspective, hopefully, for your own benefit.

### **What will happen when the research study stops?**

During the study all recordings/transcripts/data will be anonymised, encrypted and stored securely. In line with the British Psychological Society guidelines, all transcripts will be kept under safe storage for five years after the completion/publication of this research. When the research requirements are fulfilled the recordings/transcripts/data will be permanently destroyed.

### **Will my taking part in the study be kept confidential?**

- The researcher and the research supervisor will be the only individuals to have access to all the data before anonymizing.
- All data will be anonymized, encrypted and stored securely.
- Anonymized data and recordings may be accessed by other staff within the Psychology department of City, University of London.
- Data will be treated with respect to privacy and no breach of confidentiality will occur unless incidents of violence, abuse, self-inflicted harm and harm to others will be reported. This is to ensure your and other people's safety.
- Data and records will be permanently destroyed once the research requirements are fulfilled.

### **What will happen to the results of the research study?**

The information gathered from this research will be part of a thesis for the requirements of the doctorate programme in Counselling Psychology at City, University of London. This implies that other staff and students will be able to access and read the outcome of this research. It is possible that other people might be able to access it in case the outcome of the study gets published. The anonymity of participants will be maintained in all these instances.

It is also possible for you to receive a summary of the themes that will emerge from your interview. You can e-mail your request to [REDACTED] any time after the interview takes place.

### **What will happen if I don't want to carry on with the study?**

If at any point you wish not to carry on with the study, you are free to leave, without having to provide explanation or receive any sort of penalty or disadvantage.

You may wish to withdraw the information and data you have provided for this research at any time **up to one month after your interview date**. After that date, data withdrawal may not be possible as the analysis of the data will be processed and submitted for presentation and evaluation to the Psychology department of City, University of London.

### **What if there is a problem?**

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone [REDACTED] [REDACTED]. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: ***How do self-identified gay men in the UK experience unhelpful incidents in talking therapy.***

You could also write to the Secretary at:

[REDACTED]  
Secretary to Senate Research Ethics Committee  
Research Office, E214  
City, University of London  
Northampton Square  
London  
EC1V 0HB  
Email: [REDACTED]

City, University of London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal

rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

**Who has reviewed the study?**

This study has been approved by City, University of London *[insert which committee here]* Research Ethics Committee, [Reference: PSYETH (P/L) 16/17 68].

**Further information and contact details**

Researcher: Michail Televantos E-mail: [REDACTED]

Research Supervisor: [REDACTED] [REDACTED]

**Thank you for taking the time to read this information sheet.**

### **Appendix C: Screening Phone Call**

**Researcher:** Hello. Thank you for expressing interest in my research on how do self-identified gay men in the UK experience unhelpful incidents in talking therapy. May I begin by asking you a few questions to see if you qualify for this study? This will take only a few minutes. I will be happy to answer any questions or concerns you have afterwards.

Let me begin by asking if you identify as a gay man?

Has your unhelpful experience in therapy occurred after the year 2014?

Have you completed your therapy at least 6 months ago?

To what extent do you believe that the unhelpful experience you might be talking about in the interview was related to or impacted by your sexual identity?

***If potential participant does not respond positively to the above questions, the researcher will tentatively communicate to the potential participant that this research is not suitable for his case and thank him for his consideration and time.***

***If the potential participant responds positively to the questions above, the researcher will proceed with the phone interview screening as follows:***

**Researcher:** Do you currently drink alcohol or use other medications or drugs that you feel might cause you some difficulties in remembering things or concentrating (for example reading the newspaper)?

As the topic we will be covering in our interview will be of sensitive nature, I am interested to very briefly discuss with you how would you describe your mental and emotional health in this stage of your life?

Sometimes, after unhelpful incidents and difficult experiences people may have thoughts of ending their life or self-harming in some way. Is this something that happened to you?

***The researcher will use his clinical skills to estimate whether the potential participant is suitable for the study and ask him or her to schedule a time and location for the interview.***

***Otherwise, the researcher will tentatively acknowledge that this study is not suitable for the potential participant. If it appears relevant and appropriate, the researcher will sign post the potential participant to his nearest A & E service or other relevant mental health services (also mentioned in the debrief form).***

***The researcher will then thank the potential participant for his time and consideration.***

#### ***Appendix D: Background Questionnaire***

- 1) What is your age?
- 2) What is your ethnic background?
- 3) What is your highest level of completed education?
- 4) When did you have the talking therapy in which the unhelpful incident happened?
- 5) How long was this therapy (how many sessions/weeks/months)?
- 6) Have you had another experience of therapy? If yes, when and for how long?

### ***Appendix E: Interview Schedule***

- 1) Can you tell me about the unhelpful experience you had in therapy?
- 2) What was it like to be in that situation?
- 3) What sense did you make of it? What did it mean for you at that time?
- 4) How did it affect your relationship with the therapist?
- 5) How did it affect your process of therapy?
- 6) How else did it affect you?
- 7) What would you like to have happened instead?
- 8) What sense/meaning do you give to this unhelpful experience now?



## Appendix F: Sample of Individual Participant Transcript Analysis

Participant's Pseudonym: Thomas			
Emergent Themes		Original Transcript	Exploratory Comments
Seeking therapy after a long term relationship ended.	1 2 3 4	Mike: So... Tell me a bit about the unhelpful experience you had in therapy... Thomas: Um... So... Um... Maybe to give you some context to... My therapist was also a gay man...	Repetition of 'Um' and slower pace of speech (marked by '...'). Is there an underlying difficulty in articulating something that is emotive and complex? Describes the context of his unhelpful experience in terms of therapist also being a gay.
The unhelpful incident is in relation to sexuality.	5 6 7 8 9 10 11 12	Mike: Mm... Thomas: And... Um... And I had gone to therapy ... For two reasons... Probably to get some support for the ending of a relationship that I had been in for... Around four years... Mike: Mm... Thomas: And because I was also doing a counselling course at that time and it was a requirement for my course to also be... Mike: I see...	Seems important to explain context in order to make me understand more his experience? Time was crucial for him as he had just ended a 4 year relationship. Thomas went for therapy because it was his university course requirement but also because he wanted support for his relationship ending. He divides his therapy engagement to have internal but also external motivational factors. Trying to partially disengage his internal world from a painful process? He mentions his need for support on relational matters first and then the external need.
Time together allowed the build of a descent relationship.	13 14 15 16 17 18 19	Thomas: ... In therapy... Um... But the incident that I am thinking of relates to the sexual relationship I had with my partner... Mike: Mm... Thomas: And so... I ... This would have... This probably would have occurred... Quite a few months into therapy... So I think we had established a decent enough relationship...	His unhelpful experience in therapy relates to the sexual relationship he had with his partner. Is there a difficulty in recalling when the unhelpful incident happened in therapy course? Not confident as to how good the relationship was? ('So I think'). There was a 'decent enough' relationship with therapist. Or did he mean he would have expected or hoped that after few months a decent relationship would have been established?

Client wanting to explore his hidden and private concern of sexuality in therapy	20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42	Mike: Yeah... Thomas: Um... But... Um... I guess after initially working through some of my feelings about the ending of the relationship... There was some exploration I wanted to do around my sexual relationship with the... that guy that I had been in a relationship with... Mike: Yeah... Thomas: Um... And I, I disclosed to the therapist that myself and my ex had had a threesome... Mike: Mm... Thomas: ...With a friend, a mutual friend of ours... Mike: Yeah... Thomas: And... And I wanted to explore with him the implications of that in terms of... Mm... My relationship with my boyfriend at that time... And... Mike: Yeah... Thomas: ... He... He went silent... He didn't... He didn't say anything... Mike: Mm mm... Thomas: And when I think I... Just wanted to check-eye with him... How, how he felt ... Mike: ...Yeah... Thomas: ... By what I had just told him...	Repetition of 'Um' could suggest struggle to articulate something confusing or emotive. In addition, 'but' could suggest a contrast following the 'established [...] descent enough relationship...'. He used therapy to initially work through break up and then wanted to explore his sexual relationship with his past partner. 'I guess after initially working' could suggest that either what would follow was more uncomfortable or of less urgent at the beginning of therapy? 'with the... that guy' difficulty to articulate the person he was in relationship with perhaps because of difficult or unclear feelings attached to that person then or maybe now too. 'Um' and 'disclosed' would suggest that the topic was sensitive for him. Could it underlie a feeling of shame or embarrassment? He wanted to explore the implications of the threesome with the relationship he had with his then boyfriend. Therapist's response was silence. Hesitant in speech and repetition could imply an underlying confusion of what the reaction actually was. Anger as a hidden feeling with this silent response? Maybe silence felt very uncomfortable after 'disclosing, and perhaps feeling exposed? Maybe felt vulnerable but not contained?' 'Check-eye with him'. Is Thomas trying to connect after daring to become vulnerable? Test trust? [...] how he felt'. Pivotal emotional moment in the therapy process? Attempting relational contact?
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Outrageous response of therapist	43	Mike: Yeah...	Verbal response was also unhelpful.
	44	Thomas: Um... And... His response was quite unhelpful. I think	'um', slower pace of speech (marked by '...') and 'quite', 'I think' could suggest a confusing internal experience difficult to access?
	45	he said...	
	46	Mike: Mm...	Thomas recalls that the therapist responded with a reference to his extensive work experience in sexual health with gay men, hearing details of their sex lives but not 'getting off on it'. Thomas didn't know how to respond to that.
	47	Thomas: ...To me, "look, I have worked in... Sexual health for a	
Feeling confused	48	very long period of time"...	I'm aware of my own reaction, felt outraged.
	49	Mike: Mm mm....	'Um' and I didn't 'quite know' can show how difficult it was/is for him to understand what was happening and to access his emotional experience.
	50	Thomas: ... " With gay men, talking about all the ins and outs of	He felt confused? Perhaps attacked, as if he had to respond and defend himself?
	51	their sex life"....	
	52	Mike: Mm...	
Fear to be judged	53	Thomas: Um... "... And I have no interest in all of the ins and	
	54	outs of people's sex lives" ... "I don't get off on it" ... It was his	
	55	words....	Repetition of 'I think I was' can suggest difficulty in accessing his emotional response to therapist's reaction. He was anxious and nervous to disclose having had threesome with his boyfriend to his therapist.
	56	Mike: Yeah...	'Something like this' - could show shame and embarrassment in disclosing having threesomes with his partner to therapist.
	57	Thomas: Um... And I didn't quite know how to respond to that...	To what extent did his fantasies colour the experience of the therapist's response? Daring to be vulnerable and being take aback by therapist's response. He was concerned about being judged by therapist for having had threesomes with his partner.
Pre-existing shame.	58	Mike: Yeah... Because as you say it, I get I sense that it wasn't	
	59	not what you expected... To hear from your therapist...	
	60	Thomas: No, definitely not... Um... I think I was, I think I was	
	61	really... Um... Anxious and nervous about...	
	62	Mike: Mm mm....	
	63	Thomas: ...Disclosing something like this to him...	
	64	Mike: Yeah...	

Therapist perpetuating pre-existing shame	65	Thomas: Um... Because I was concerned that maybe ... Um...	Thomas was worrying that his relationship might have not been as good as he thought and that his therapist would now confirm that. <b>Worst fear confirmed?</b>
	66	Maybe he would judge me for it...	
	67	Mike: Mm mm...	Almost as if Thomas is thinking "I came here to become vulnerable and this is what I get?" Wanted to be accompanied and make sense of what he perhaps perceived as darker parts of self (Mearns and Thorne) and was blocked by therapist's response?
	68	Thomas: Or that he would confirm something that I was worried	
	69	about, which was maybe my relationship with my ex wasn't as	
Vulnerability and need for connection met with ambiguity and judgment	70	good as I thought it was... Because...	Repeating 'his' perhaps suggest that Thomas is still struggling to make sense of a response coming from him (therapist). Regardless the pre-existing worries, Thomas felt surprised by his therapist's unclear response as to whether he is welcome to open up. <b>Or worried that he was being judged?</b>
	71	Mike: I see...	
	72	Thomas: ... We had an open-relationship if that makes sense...	
	73	Mike: I see...	He didn't expect that response. Saying 'really' can show how unexpected this particular response was. Referring to my name perhaps shows that Thomas wants the listener (myself) to pay attention and come closer to him. <b>Perhaps he felt exposed and distant in that moment and wished someone was able to go close to him and try to listen and understand him?</b>
	74	Thomas: So... His, his response took me by surprise...	
Difficulty to be vulnerable but also a great need for someone to understand.	75	Because it wasn't quite clear whether he was saying to me...	Thomas clarifies that he didn't feel comfortable talking about sex in therapy regardless. 'Even though he was a gay man' might imply Thomas's expectation or hope that because therapist was gay, Thomas would have felt more comfortable to speak about sex in therapy. It also shows his surprise of the therapist's response. <b>Given that having a gay therapist seems important for Thomas, this perhaps shows how much he was longing to be able to feel comfortable to speak and make sense about the specific topic of his 'open-relationship'.</b> perceived a sense of vulnerability being faced with judgemental response, suggesting that therapist was not able/willing to go where Thomas wanted him to be with him?
	76	Mike: Mm...	
	77	Thomas: ... "You can talk about this"...	
	78	Mike: Mm mm...	
	79	Thomas: "I want to hear about this" ... Or, Um... It... Yeah... I,	
	80	I, I... It was really unexpected Mike ...	
	81	Mike: Mm mm mm mm... And ... When you say that... You also	
	82	said... Initially that you were... was, was ... I guess you were	
	83	trying as well to ... To see as well... You were a bit concerned	
	84	.... Conscious of what his reaction might be?	
	85	Thomas: Yeah... Um... I think there's two reasons for that.	
	86	Mike: Mm...	

## Appendix G: Clustering Themes for Individual Cases



## **Appendix H: Ethical Approval**



Psychology Research Ethics Committee  
School of Arts and Social Sciences  
City University London  
London EC1R 0JD

2<sup>nd</sup> December 2016

Dear Michail Televantos [REDACTED]

**Reference:** PSYETH (P/L) 16/17 68

**Project title:** How do self-identified gay men in the UK experience unhelpful incidents in talking therapy

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

### Period of approval

Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

### Project amendments

You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

- (a) Recruit a new category of participants
- (b) Change, or add to, the research method employed
- (c) Collect additional types of data
- (d) Change the researchers involved in the project

### Adverse events

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee [REDACTED] in the event of any of the following:

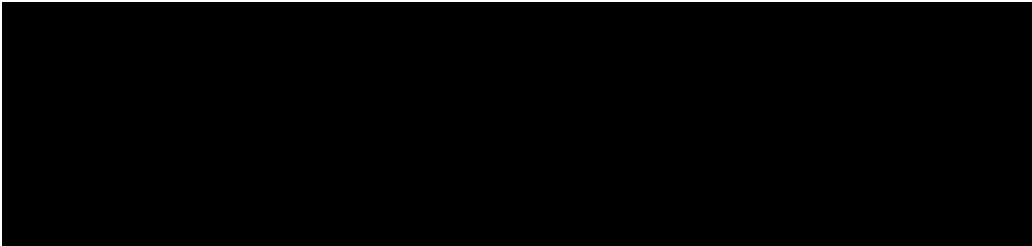
- (a) Adverse events
- (b) Breaches of confidentiality
- (c) Safeguarding issues relating to children and vulnerable adults

(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards



## Appendix I: Consent Form



Title of Study: ***'How do self-identified gay men in the UK experience unhelpful incidents in therapy'***

Ethics approval code: *PSYETH (P/L) 16/17 68*

Please initial box

1.	<p>I agree to take part in the above City, University of London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.</p> <p>I understand this will involve:</p> <ul style="list-style-type: none"><li>• Completing a background questionnaire about my age, ethnicity and education, and my experience with talking therapies.</li><li>• Being in an individual interview with the researcher.</li><li>• Being interviewed about my unhelpful experience in talking therapy that I believe to have been related to my sexual identity.</li><li>• Allowing the interview to be audiotaped.</li><li>• The outcome of the interview being presented in a research paper/thesis using pseudonyms.</li></ul>	
2.	<p>This information will be held and processed for the following purpose:</p> <ul style="list-style-type: none"><li>• To reach the aim of the research which is to capture as closely as possible the participant's subjective experience and meaning making of an unhelpful incident in talking therapy.</li></ul> <p>I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.</p> <p>I understand that it is possible for me to request that the researcher share a summary of the themes that will emerge from my interview.</p>	
3.	<p>I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw</p>	



	<p>without being penalized or disadvantaged in any way.</p> <p>I understand that I can withdraw my participation at any point during the interview and within the space of one month after the interview has taken place. After that time, data withdrawal may not be possible as the analysis of the data will be processed and submitted for presentation and evaluation to the Department of Psychology at City, University of London.</p>	
4.	I agree to City, University of London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Name of Participant	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Signature	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Name of Researcher	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Signature	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date

When completed, 1 copy for participant; 1 copy for researcher file.

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Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

## Appendix J: Debrief Information



### *How do self-identified gay men in the UK experience unhelpful incidents in therapy'*

#### DEBRIEF INFORMATION

Thank you for taking part in this study. Now that it's finished we'd like to tell you a bit more about it.

This study aims to try to understand the individual and unique experience of unhelpful incidents in therapy as lived by gay men. By using a semi-structured interview it was hoped that you as a participant will have both some guide but also the freedom and space to convey what this experience was like for you and what sense you made of it and what meaning you gave to this experience.

By shedding light on these individual experiences it is hoped that counselling psychologists and other therapists will be invited to expand their empathic understanding when working with gay men. It is hoped that this information can result in a more competent and ethical practice that values the subjective experience of each individual.

It is possible that the interview has brought unpleasant emotions and thoughts to your awareness. If that is the case it could be of help to contact your GP. Below we include some websites and telephone numbers that can help you to access therapeutic support.

- Website with information regarding **Mind** and **NHS** IAPT talking therapies:  
<http://www.mind.org.uk/information-support/drugs-and-treatments/talking-treatments/finding-a-therapist/#.V4eYTDWeA6Y>
- **British Psychological Society** website with a list of **Chartered Psychologists**:  
<http://www.bps.org.uk/bpslegacy/dcp>
- London **Samaritans** helpline and website:  
**Free Call** :116 123 (UK)  
**National telephone:** 020 7734 2800 (Branch)  
<http://www.samaritans.org/branches/central-london-samaritans>

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:

Researcher (first point of contact): Michail Televantos

[REDACTED]  
[REDACTED]  
[REDACTED]

Ethics approval code: *PSYETH (P/L) 16/17 68*



***Appendix K: Research Journal***

